PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 06/07/2012				
	PROVIDER OR SUPPLIEF			5843 N	ADDRESS, CITY, STATE, ZIP CODI SHERMAN AVE				
COMMU	COMMUNITY ALTERNATIVES-ADEPT			INDIANAPOLIS, IN 46220					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECT	TON	(X5)		
PREFIX	`	ICY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR				
TAG W0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE		
			W00	00					
	This visit was for the extended								
	recertification ar	nd state licensure survey.							
	Dates of Survey:	: May 29, 30, 31, June 1,							
	4, 5, 6, and 7, 20								
	Facility Number	: 000936							
	Provider Numbe								
	AIMS Number:	100244610							
	Surveyors:								
	Susan Eakright,	Medical Surveyor							
	III/QMRP-Team	•							
	Amber Bloss, M								
	III/QMRP								
	These federal de	ficiencies also reflect							
	_	accordance with 460 IAC							
	9.								
		mpleted 6/14/12 by Ruth							
	Shackelford, Medic	al Surveyor III.							

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 X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		15G422	A. BUII B. WIN			06/07/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹				
COMMUN	NITY ALTERNATIV	ES ADEDT			I SHERMAN AVE IAPOLIS, IN 46220	
	MILL ALILINATIV	LO-ADEI I		INDIAN		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0104						
	GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over					
	the facility.	and operating direction over				
	and radimity.		W0	104	CORRECTION: The governing	07/07/2012
	D 1 1	-4:	" "	101	body must exercise general	, 0770772012
	Based on observation, record review, and				policy, budget, and operating	
	-	of 7 clients (clients #1,			direction over the facility.	
		6, and #7) who resided in			Specifically, Missing hardware	on
	the home, the go	verning body failed to			bedroom furniture has been	
	exercise operating	ng direction over the			replaced, the abnormally loud	
	group home to en	nsure maintenance was			vacuum has been replaced an	
	completed which included missing light				all light fixtures are equipped working light bulbs.	vitti
	•	vacuum cleaner, the			PREVENTION: Professional	
	•	ws, and missing hardware			staff will be retrained regarding	g
	on the bedroom	•			the need submit requests for	
	on the bearoom.	iuimture.			repairs upon discovery of	
					maintenance needs, as well as	3
	Findings include	: :			the need to conduct ongoing	
					assessments of the home's	
	On 5/29/12 from	1 5:25pm until 7:15pm,			environment to identify maintenance and safety issue	e
	and on 5/30/12 f	rom 5:25am until			Members of the Quality	5
	8:20am, clients #	#1, #2, #3, #4, #5, #6, and			Assurance and Operations	
		ghout the group home,			Teams will periodically perform	n
	1	edrooms, and the two			home environment audits and	on
		ms. The two hallway			ongoing basis to assure	a .
	1	missing light bulbs. The			appropriate upkeep occurs at	ine
					facility and to assist with expediting purchases as	
		m had three of three (3/3)			appropriate. RESPONSIBLE	
		lbs above the sink and			PARTIES: QDDPD, Home	
		1 and #6's bedroom had			Manager, Support Associates,	,
	` ′	white vinyl windows			Operations Team, Quality	
	with a black sub	stance covering the			Assurance Team	
	window casing is	nside the length and			CORRECTION: The governing	7
	width of the win	_			body must exercise general	
					policy, budget, and	
	On 5/20/12 of 75	om, client #5 got out the			operatingdirection over the	
	On 3/29/12 at /p	nn, chem #3 got out the	ı		facility. Specifically, Missing	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G422	B. WIN			06/07/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	<u>t</u>		5843 N	SHERMAN AVE	
	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	· ·	DATE
	_	and clients #1, #2, #4, #6,			hardware on bedroom furniturehas been replaced, th	e
	and #7 were watching television in the			abnormally loud vacuum has		
		ent #5 plugged in the			been replaced and all lightfixtu	ıres
	vacuum and the	vacuum motor made a			are equipped with working ligh	nt
	_	nding sound. Client #2			bulbs. PREVENTION:	_
	put her hands ov	er her ears then stated to			Professional staff will beretrain regarding the need submit	nea
	GHS (Group Ho	me Staff) #2 "It vibrates			regarding the need submit requests for repairs upon	
	the windows too	." GHS #2 stated "It			discovery ofmaintenance need	ds,
	needs a belt." C	lients #1, #2, and #7			as well as the need to conduct	
	indicated the vac	euum was loud and they			ongoing assessments of	
	did not like the s	-			thehome's environment to ide	
					maintenance and safety issue Members of the Quality	S
	On 5/30/12 at 6:	30am, GHS #4 stated the			Assurance and OperationsTea	ams
		on client #1 and #6's			will periodically perform home	
		vs was "mold." GHS #4			environment audits and on	
		aned the other windows			ongoing basis toassure	
					appropriate upkeep occurs at facility and to assist with	tne
		tance in the group home			expeditingpurchases as	
		ed she "was not allowed			appropriate. RESPONSIBLE	
		1 and #6's bedroom			PARTIES: QDDPD, Home	
		t because the clients were			Manager, SupportAssociates,	
	1 .	0am, GHS #4 indicated			Operations Team, Quality	
		#6, and #7's dressers			Assurance Team	
	_	hardware to pull their				
		open. GHS #4 indicated				
		8, #6, and #7 needed				
	hardware on their	r bedroom furniture. At				
	6:30am, GHS #4	indicated clients #1, #2,				
	#3, #4, #5, #6, aı	nd #7 used the hallway				
	bathrooms and needed light to bathe, shave, and personal hygiene. GHS #4 stated she "did not know" how long the light bulbs were missing.					
		<u> </u>				
	On 5/30/12 at 8::	20am, the facility's				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	E SURVEY PLETED 7/2012	
	PROVIDER OR SUPPLIER		5843 N	ADDRESS, CITY, STATE, ZIP C I SHERMAN AVE NAPOLIS, IN 46220	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	requested from the (Qualified Mental Professional Desindicated no main was available for On 5/30/12 at 12 Maintenance and log/communication requested from the (Qualified Mental Professional Desindicated no main was available for On 5/31/12 at 9:4 Maintenance and log/communication requested from the (Qualified Mental Professional). A indicated no main was available for On 6/1/12 at 10:4 the QMRP was condicated no main was available for the QMRP was condicated no main requested from the QMRP was condicated no main was available for the QMRP was condicated no main requested from the QMRP was condicated from the QMR	on information was the agency's QMRP-D al Retardation ignee). The QMRP-D intenance information review. :20pm, the facility's Repair on information was the agency's QMRP-D al Retardation ignee). The QMRP-D intenance information review. 45am, the facility's Repair on information was the agency's QMRP al Retardation to review. 45am, the facility's Repair on information was the agency's QMRP al Retardation to 3:40pm, the QMRP intenance information review.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
		15G422	A. BUII B. WIN			06/07/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE		
CONANALI	NITY ALTERNATIV	EC ADEDT					
COMMO	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	.5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPL	ETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Œ
W0122	483.420						
	CLIENT PROTE	CTIONS					
	The facility must ensure that specific client						
	protections requi	rements are met.					
			W0	122	CORRECTION: The facility mu	ıst 07/07/	/2012
	Based on record	review and interview, the			ensure that specific client		
		ticipation of Client			protections requirements are r	net.	
		_			Specifically, The facility must		
		t met for 4 of 4 sample			develop and implement writter		
	`	1, #2, #3, and #4) and for			policies and procedures that		
	3 additional clier	nts (clients #5, #6, and			prohibit mistreatment,neglect of		
	#7). The facility	failed to ensure clients			abuse of the client. Specifically	′,	
	were not subjecte	ed to the potential of			the staff responsible for an	of	
		nd/or mistreatment, failed			incident of neglect and misuse client property on 5/15/12 has	OI	
					been terminated. a BDDS		
	•	facility's policy and			Incident report will be submitte	d	
		hibit abuse, neglect,			regarding staff misuse of client		
	and/or mistreatm	ent, failed to report and			#3's library card. Additionally,		
	investigate allega	ations of abuse/neglect			follow-up reports will be submi	ited	
	and unknown ini	uries, failed to complete			to the BDDS regarding the res	ults	
		and failed to report the			of investigations into incidents		
		gations within 5 working			that occurred on 10/17/11 (2),		
	`	gations within 5 working			10/27/11, 12/27/113/25/12,		
	days.				3/27/12, 4/21/12 and 5/15/12.		
					Investigations will be complete for Client #7's injury of unknow		
	Findings include	:			origin on 10/27/11, client #3's	"	
					suicidal gesture on 3/25/12, Cl	ient	
	Please refer to W	149. The facility			#3's elopement incident on		
		lement its Abuse/Neglect			3/27/12 and client to client		
		•			aggression between Client #3		
		ients (clients #1, #2, #3, #4,			and Client #6 on 4/21/12.		
		nmediately report unknown			PREVENTION: An additional		
		ons of staff abuse, neglect			level of supervision has been		
		according to state law, ghly investigate and report the			added to the facility's		
		ions for unknown injuries and			organizational structure. A Hor		
	allegations of staff a				Manager will be reporting direct		
	_	ure clients were not subjected			to the QDDP to facilitate timely	′	
	to staff abuse, negle				reporting, prompt investigation		
	w suit aduse, negle	or, or improvement.			and implementation of correcti	ve	
					measures as well as follow-up	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15G422	B. WIN			06/07/2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			1	SHERMAN AVE	
COMMU	NITY ALTERNATIV	ES ADEDT				
COMMO	NIIT ALIERNAIIV	ES-ADEPT		INDIAN	APOLIS, IN 46220	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Please refer to W	153. The facility failed			with appropriate parties as	
	for 3 of 24 BDDS reports reviewed and			required. Facility professional		
		gations of injuries of		staff will receive be provided with		vith
		2			clear expectations regarding	
	_	and allegations of abuse,			reporting, follow-up and	114.
	•	nistreatment reviewed			investigation of incidents. Faci supervisory staff will be retrain	
	· ·	2, #3, #4, #5, #6, and #7)			regarding agency investigation	
	to immediately re	eport to the			procedures, with emphasis on	
	Administrator in	accordance to state law			timely completion. Retraining v	vill
	allegations of ab	use, neglect, and/or			focus on the need to develop a	I
	_	l injuries of unknown			maintain sound time	
	origin.	injuries of unitiown			management skills and to requ	
	origin.				assistance from the Operation	
					Team as needed. Additionally,	I
		154. The facility failed			training will stress the importar	I
	,	Bureau of Developmental			of prioritizing facility support ta	I
		reports of abuse, neglect,			to assure that alleged violation are investigated without delay	
		and injuries of unknown			that follow-up occurs as require	
		3, #6, and #7), to complete a			The Quality Assurance and	Jul 1
		on for allegations of abuse,			Operations Teams will monitor	•
	unknown origin.	reatment and injuries of			compliance with investigation	
	ulikilowii origili.				timelines and coordinate	
					corrective measures as neede	d.
		156. The facility failed			PREVENTION:	
	for 6 of 24 BDD	S (Bureau of			RESPONSIBLE PARTIES:	
	Developmental I	Disability Services)			QDDPD, Home Manger, Supp	ort
	reports reviewed	and for 2 of 3			Associates, Operations Team,	
	_	viewed to report the			Quality Assurance Team	
	"	gations within 5 working				
		c c				
		£1, #2, #3, #4, #5, #6, and				
	#7.					
	Please refer to W	157. The facility failed				
	for 5 of 24 BDD	S (Bureau of				
	Developmental Disability Services) reports reviewed and 2 of 3 investigation					
		_				
	reports reviewed	to complete effective				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/07/2012
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE	
COMMU	JNITY ALTERNATI\	/ES-ADEPT		IAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED 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
	origin and allega and/or mistreatm #2, #3, #4, #5, #	n for injuries of unknown ations of abuse, neglect, nent to protect clients #1, 6, and #7 from the se, neglect, and/or			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		15G422	B. WIN			06/07/2012	
		<u> </u>	Γ		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			I SHERMAN AVE		
	NITY ALTERNATIV			INDIAN	NAPOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	PLETION
TAG				TAG	DEFICIENCY)	D.F	ATE
W0140	483.420(b)(1)(i) CLIENT FINANC	res					
	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.						
			W0	140	CORRECTION: The facility me		7/2012
	Based on observ	ration, record review, and			establish and maintain a syste		
		cility failed for 4 of 4			that assures a full and comple		
		clients #1, #2, #3, and #4)			accounting of clients' personal funds entrusted to the facility of		
					behalf of clients. Specifically,		
	and for three additional clients (clients #5, #6, and #7) to maintain a system which				team will complete updated		
		•			financial assessments for all		
	_	ete accounting of clients'			clients and develop money		
	personal funds.				disbursement protocols in		
					accordance with their current		
	Findings include	e:			budgeting skills. Professional	,	
					staff will maintain an up to dat ledger to track purchases for a		
	On 5/30/12 from	n 5:25am until 8:20am,			clients including a daily sign-o		
	clients #1, #2, #3	3, #4, #5, #6, and #7			log for money tobe spent at da		
	indicated they lil	ked to carry their own			service and workshops. All sta	ff	
		to have their money to			will assure that clients provide		
		o, and did not have their			receipts for purchases as		
	1	available to them.			appropriate and the Home Manager will maintain copies	of	
	personal money	available to them.			receipts for purchases recorde		
	On 5/20/12 at 7.	10am aliant #1 #2 #2			on the ledgers. PREVENTIO		
		40am, client #1, #2, #3,			The Home Manager will maint		
		7's personal financial			responsibility for maintaining		
		requested for review at			client financial records and the		
		and the Residential			QMRP will audit these records		
	Manager (RM) i	ndicated no petty cash			less than weekly. All staff will retrained regarding the need t		
	was available in	the group home for			assist clients with budgeting a		
	clients #1, #2, #3	3, #4, #5, #6, and #7. At			collecting receipts.The Home		
	7:40am, the RM	stated clients received			Manager will turn in client		
	money "every week or so, sometimes				financial records to the Busine		
		nt their money with staff.			manager no less than monthly	for	
		ed there were no receipts.			review and filing. Additionally,		
	i inc inivi indicate	a more were no receipts.	1		members of the Operations ar	iu [

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G422	B. WIN			06/07/	2012
NAME OF I	DDOLUDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			5843 N	SHERMAN AVE		
	NITY ALTERNATIV				APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
IAG	+		+	TAG	Quality Assurance Teams will		DATE
	•	ed blank balance sheets			include audits of client finance	s	
	for 5/2012 for clients #1, #2, #3, #4, #5,				as part of an ongoing facility a		
	1	RM indicated the			process. RESPONSIBLE		
	following inform	nation:			PARTIES: QDDPD, Home		
					Manger, Support Associates,		
	-Client #4 had no	o money use recorded for			Operations Team, Quality Assurance Team		
	5/2012 and no balance recorded.				Assurdince rediff		
	-Client #7 had no	o money use recorded for					
	5/2012 and no balance recordedClient #3 had been approved to carry \$10.00 by the agency Interdisciplinary Team, she had received \$10.00 on						
	1	record of 5/2012 money					
		d. Client #3 had no					
	balance recorded						
		o money use recorded for					
		been approved to carry					
		1 had no balance					
	recorded.	-1 had no barance					
		een approved to carry					
	•	ived \$20.00 in 4/2012 no					
		d, and had no money use					
		012. Client #6 had no					
	balance recorded						
		o money use recorded for					
	5/2012, had rece	eived \$10.00 on 3/16/12					
	and 2/24/12, and	had been approved to					
	carry \$10.00. Cl	lient #5 had no balance					
	recorded.						
	-Client #2 had no	o money use recorded for					
	5/2012, had been	n approved to carry					
	\$10.00, and had	received \$10.00 on					
		12. Client #2 had no					
	balance recorded						

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	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		15G422	A. BUI. B. WIN	LDING G		06/07/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	1	
					SHERMAN AVE		
	NITY ALTERNATIV			<u> </u>	APOLIS, IN 46220		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	On 5/30/12 at 12 (Qualified Menta Professional-Descash was not kep QMRP-D indicated was for clients to then forward the agency issues an bank, the client gretrieves their furindividually keep QMRP-D indicated track how often and track how often and the clients agency for the clients agency for the clients #1, #2, #3. "Accounting" for checks for withdate fee, and indicated receipts for "special and indicated and and client funds were the QMRP-D in clients' personal by the agency on The QMRP-D in not available at the cash was not a special professional and the professional and the professional by the agency on The QMRP-D in not available at the cash was not keep QMRP-D in the QMRP-D in the quality personal by the agency on the QMRP-D in not available at the cash was not keep QMRP-D in the quality personal by the agency on the quality personal by the agency of the quality personal by the agency o	:45pm, the QMRP-D					

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Event ID: 3RYA11

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PRINTED: 07/05/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15G422	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 06/07	LETED
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	5843 N	ADDRESS, CITY, STATE, ZIP C SHERMAN AVE IAPOLIS, IN 46220	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	funds. The QMRP-D indicated there was not a complete accounting of client #1, #2, #3, #4, #5, #6, and #7's personal funds.				
	9-3-2(a)				

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Event ID: 3RYA11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SUF	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETE	ED
		15G422	B. WIN			06/07/20	12
			p. ,,		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) 483.420(d)(1)			TAG	DEFICIENCY)		DATE
W0149	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit						
	•	eglect or abuse of the client.					
	modecatinont, ne	great or abase or the orient.	W ₀	149	CORRECTION: The facility mu	ist 0	7/07/2012
	Based on interview, and record review, for 7 of 7 clients (clients #1, #2, #3, #4,		""	,	develop and implement written		,,0,,2012
					policies and procedures that		
					prohibit mistreatment, neglect		
		the facility neglected to			abuse of the client. Specifically	y, a	
	•	buse/Neglect policy to			BDDS Incident report will be submitted regarding staff misu		
	immediately report unknown injuries and				of client #3's library card.	36	
		ff abuse, neglect and/or			Additionally, follow-up reports	will	
	mistreatment according to state law,				be submitted to the BDDS		
	neglected to thor	oughly investigate and			regarding the results of		
	report the results	of investigations for			investigations into incidents th	at	
	unknown injuries	s and allegations of staff			occurred on 10/17/11 (2), 10/27/11, 12/27/11, 3/25/12,		
	abuse, neglect, a	nd mistreatment to ensure			3/27/12, 4/21/12 and 5/15/12.		
	clients were not	subjected to staff abuse,			Investigations will be complete	ed	
	neglect, or mistre				for Client #7's injury of unknow	vn	
	Findings include				origin on 10/27/11, client #3's suicidal gesture on 3/25/12, Cl #3's elopement incident on 3/27/12 and client to client	lient	
	 1 On 5/20/12 at	4pm, the facility's			aggression between Client #3		
		of Developmental			and Client #6 on 4/21/12.		
	Disability Service	*			PREVENTION: An additional		
		30/12 at 12:30pm, the			level of supervision has been		
		• •			added to the facility's organizational structure. A Hor	mo	
	·	ations were reviewed.			Manager will be reporting direct		
		cated the following			to the QDDP to facilitate timely	-	
		use, neglect, and/or			reporting, prompt investigation		
	mistreatment:				and implementation of correcti		
					measures as well as follow-up		
	-A 5/16/12 BDD	S report for an incident			with appropriate parties as required. Facility professional		
	on 5/15/12 at 7:3	0pm, indicated when a			staff will receive be provided w	_{/ith}	
	"day shift staff re	eported to work (on			clear expectations regarding		
	5/16/12) [client #	f6] told her that on the			reporting,follow-up and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		15G422	B. WIN			06/07/2012	
C OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		5843 N	SHERMAN AVE		
	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
	1 ^	g when [Group Home			investigation of incidents. Faci supervisory staff will be retrain		
	` ′ -	was transporting he and			regarding agency investigation		
		nome from the library			procedures, with emphasis on		
	(clients #1, #2, #	3, #4, #5, #6, and #7) she			timely completion. Retraining v	I	
	detoured into an	apartment complex and			focus on the need to develop a	and	
	they observed a i	man yelling at and hitting			maintain sound time	oot	
	a woman who wa	as holding a child.			management skills andto requiassistance from the Operation	I	
	[Client #6] allege	ed that [GHS #6] got out			Team as needed.		
	1 2 2	he individuals without			Additionally,training will stress	the	
	· ·	chased after the man.			importance of prioritizing facilit	у	
		semates corroborated his			support tasks to assure that		
	1 -	nts #1, #2, #3, #4, #5, #6,			alleged violations are investiga without delay and that follow-u		
	_	d the man [GHS #6] was			occurs as required. The Qualit	- I	
		earm." The report			Assurance and Operations	,	
		ported the allegation and			Teams will monitor compliance	;	
					with investigation timelines and	I	
		pended pending an		coordinate corrective measures		S	
	investigation.				as needed. RESPONSIBLE PARTIES: QDDPD, Home		
					Manger, Support Associates,		
		restigation into the			Operations Team, Quality		
	•	m incident indicated			Assurance Team		
		ption:" on 5/16/12 at					
		#3, and #6 told of the					
		ay shift staff. The					
	description of the	e incident indicated "On					
	5/15/12 while ret	turning from the library					
	[GHS #6] drove	them into an apartment					
	complex in the v	icinity of [street #1] and					
	_	nme of city] and left them					
	alone on the van	• -					
	intervened in a d						
		ey said that they believed					
	<u> </u>	n the dispute had a					
		the initial course of the					
	_						
	investigation add	litional allegations					

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Event ID: 3RYA11

Facility ID: 000936

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AND PLAN OF CORRECTION IDENTIFICATION N 15G422	IUMBER:	UILDING VING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/07/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT	•	5843 N S	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220	
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PERCE TAG REGULATORY OR LSC IDENTIFYING I	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
emerged suggesting that on the Tuesday, 5/15/12, (that) [GHS # [client #3's] library card to chec movies for [GHS #6's] personal that this resulted in [client #3] in late fees of \$9.43." The 5/16/12 Investigation for the incident indicated the following statements: -Client #7 stated "Yeah honey, got out of the van. The boy hit to the van. The boy hit to the apartment and left us by our She went after this guy who hit with the baby in her hand. The came. A guy was calling [GHs b She went after him and wat him and yelling. It was a bad neighborhood around [street #1] [street #2]. Three police came. said he had a gun but I didn't see I didn't hear gunshots. [GHS #6 alone on the van. The guy called and said he would shoot her." -Client #4 stated "On Tuesday was the library. We went somewher after. [GHS #6] got off the van at to somebody."	evening of #6] used k out use and neurring le 5/15/12 witness [GHS #6] he girl." ome, ments. I ran up to selves. the girl police HS #6] a ras cussing land [GHS #6] e any gun. 6] left us d her a b we went to re else			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G422	B. WIN			06/07/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		"When [GHS #6] took					
		library, she turned into					
	an apartment bui	lding parking lot. A man					
	and a woman we	ere fighting. I didn't see					
	the man hit her.	There was a little boy					
	involved. [GHS	#6] got out of the van					
	and was fussing	at the man. [GHS #6]					
	followed [the ma	an] up the stairs in the					
	building and left	us on the van. We was					
	scared (sic). [GH	IS #6] came back and					
	` / -	because she said he					
	•	her. I didn't see the gun."					
	F	8					
	-Client #1 stated	"[GHS #6] took us to the					
		n't take us home. We					
	<u>-</u>	e else. The police came					
		et had a gun. [GHS #6]					
		n. The suspect got a gun					
	_						
		t [GHS #6]It was					
	scaryI was scar	red."					
	Client #2 state 1	"[CIIC #6] to al to 41					
		"[GHS #6] took us to the					
		stopped the van and got					
		d at her and cussed her					
		noot anybody. I was					
	scared."						
	OHO W	IT 1 11 10 T					
		'I worked by myself. I					
	, ,	myself. We went to the					
	-	ner. We were there about					
		lfI didn't check					
		t day. On my way to the					
	house, I realized	I had left one of the					

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE (COMPL	
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		15G422	B. WIN			06/07/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			SHERMAN AVE APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	the counter so I had to go					
	back. I turned ar	ound in an apartment					
	complex. I saw a	a man and a lady with a					
	baby fighting. H	le was actually beating on					
	her and she wasn	't fighting back. I did					
	stop and say som	ething to them and told					
	them I was going	g to call the police and I					
	did call the polic	eI got out on the side of					
	the van. I didn't	leave the van. I said Hey					
	that is child enda	ngerment and I'm calling					
	the policeBefore	re the police came, they					
	went into the apa	ertment building so the					
	police couldn't g	o in after them because					
	they (police) did	n't know where they					
	lived. The man	did not have a weapon. I					
	wouldn't have go	ot out of the van if there					
	_	The guy was cussing me					
	-	oot you. He was mad					
		d him from doing					
		ouldn't have been					
	doing"						
	C						
	The 5/16/12 Inve	estigation "Conclusion					
		dicated clients #1, #2, #3,					
		7 were on the van					
		ne library with GHS #6					
	_	into an apartment					
		of the van, and left the					
		ised on the van. The					
	•	icated it was verified that					
	_	not check out items from					
		se [client #3] had					
	,	l late fees" checked out					
	· ·	GHS #6's personal use.					
	<i>σ</i> y σ115 πο 101 C	no s personal use.					

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l í í			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G422	B. WING			06/07/	2012
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NUTY ALTERNATIV	EC ADEDT			SHERMAN AVE		
	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DE ICERCI)		DATE
		n conclusion indicated					
		abstantiates that the					
	actions [GHS #6	_					
		lived [in the group home]					
		ntal anguish." No					
		was available for review.					
		ts of the investigation					
		BDDS. The findings					
		ff did not return to the					
	1 -	e the library card which					
	was left behind a	it the library.					
	N. BBBG						
	_	rt was available for					
		legation of staff using					
		y card on 5/15/12 which					
	incurred late fees	S.					
	2 0 5/20/12	4 4 6 31 1 0000					
		4pm, the facility's BDDS					
	`	lopmental Disability					
	, ·	were reviewed. On					
	5/30/12 at 12:30	•					
		ere reviewed. The					
	reviews indicated	C					
	_	use, neglect, and/or					
	mistreatment:						
	A 4/00/10 DDD	.0					
		S report for an incident					
		m, indicated client #6 had					
		ility staff on day shift that					
		t #3 hit him in the chest					
		mplained that his chest					
		vestigation, corrective					
		ts of the investigation					
	reported to BDD	S were available for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G422	B. WIN	G		06/07/	2012
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
00040411		VEO ADEDT			SHERMAN AVE		
COMMU	NITY ALTERNATIV			INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	review.	LESC IDENTIFYING INFORMATION)		TAG	BETTELLINETY		DATE
	Teview.						
	A 3/31/12 RDD	S report for an incident					
	-A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3						
		en, "grabbed" a knife,					
		rt herself, and later					
	handed the knife						
		this incident and no					
	_	for incident reporting					
		or review. No results of					
	the investigation reported to BDDS were available for review.						
	-A 3/27/12 BDD	S report for an incident					
		:25am, indicated client #3					
	had gone AWOI	(Absent Without Leave)					
	from workshop t	twice; client #3 left a					
	third time running	ng into traffic down					
	[street #3] into n	noving traffic threatening					
	to commit suicid	le. The corrective action					
	was client #3 had	d not returned to day					
	services worksho	op since incident. No					
	investigation wa	s available for review.					
	No results of the	investigation reported to					
	BDDS were ava	ilable for review.					
	_	rt for this investigation					
	was available for						
	_	o a 12/27/11 incident					
		#6 "reported to [GHS #1]					
	1	24/11 he observed [GHS					
		nt #4] from exiting the					
		pping a vacuum cleaner					
	against the bathr	room door." The					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220					
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION	
TAG	investigation ind	icated GHS #1 reported		TAG	DEFICIENCY)		DATE	
	HR (Human Res which indicated corrective action failure to report s timely manner, o	icated GHS #7 had her ource) file reviewed GHS #7 "received s": Counseling 8/2/10 for suspected neglect in a n 2/8/11 for failure to eduled, and on 10/17/11						
	"for alleged phys substantiated." I indicated "Concl does not substant prevented [client bathroom by pro- against the door. investigation rep	ical abuse-not The investigation usions: The evidence tiate that [GHS #7] #4] from exiting the pping a vacuum cleaner " No results of the orted to BDDS were						
	unknown injury 10:15pm, indicat unknown "0.75 i #7's right eye. T #7's unknown br investigated" and available for revi was available for	DS report for client #7's discovered on 10/27/11 at ed staff found an each bruise under" client the report indicated client uise was "being I no investigation was ew. No corrective action review. No reported estigation to BDDS was						
	on 10/17/11 at 4:	OS report for an incident 45pm, client #6 reported tive staff that "an						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220					
				<u> </u>	11 0210, 114 10220			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE	
	_	over the past weekend"						
		ed the fire door into his						
		e weekend." The report						
		7 was "suspended						
		tigation." The 10/24/11						
	investigation con	•						
	•	rdinator (CC) indicated						
		abuse and neglect. The						
		ent #6 and GHS #7's						
	"personalities co							
		the hit, bumped into, or						
		loor because "it was						
		ident. The CC indicated						
		d client #4's unknown						
		eserved by the facility						
		and 10/16/11 and client						
		ack eye was not reported						
		No reported results of the						
	_	BDDS were available for						
	review.							
	A 10/17/11 DDI	20 10 11 1/41						
		OS report for client #4's						
		discovered on 10/17/11 at						
	•	d client #4's left eye was						
		r his eye brow with slight						
	_	estigation into the						
		t for client #6 indicated						
		nt #4's unknown black						
	_	and 10/16/11 and did not						
	-	17/11. GHS #3's witness						
		ted when she left on						
	•	"there was nothing						
		nt #4's] eye." No						
	reported results of	of the investigation to						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL 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	
	the QMRP (Qual Professional), the Manager (QAM) (QMRP-Designed QMRP indicated BDDS guideline investigate, and to completed invest Administrator act allegations of abmistreatment. The was not always of was not always of was not able to some	45am, an interview with lified Mental Retardation e Quality Assurance and the QMRP-D be) was completed. The the facility followed the sto immediately report, to report the results of the cigations to the cording to State Law for use, neglect, and/or he QAM stated "action completed" because he substantiate the allegation. In allegation in the past bestantiated, the QAM ld not recall. The QMRP the indicated staff were for reporting allegations in the QMRP both umented evidence was lew of completed.						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE (COMPL	
		15G422		LDING		06/07/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	"some" allegations had					
	_	not all" investigations					
		een reported to BDDS,					
		estigations had been					
	_	documented corrective future events had been					
	^	QMRP indicated neglect					
	•	provide services and the					
		ne QAM stated GHS #6					
		ded at this time $(6/1/12)$."					
		client #3 was reimbursed					
		e fees from her library					
		by GHS #6. The QMRP					
		\$\frac{1}{43}\$, who was an identified					
		left alone with clients					
	· ·	6, and #7 on the van on					
	5/15/12.	,					
		:30pm, the facility's					
		and procedure for					
		ement: Incident Reports					
		rtable's" was reviewed.					
		rocedure indicated the					
		d abuse, neglect, and/or					
		clients by anyone." The					
		dure indicated "All Adept					
		equired to complete a					
		report when encountering					
	-	olving changes in an					
		sical condition, mental					
	l	usual event." The policy					
		S Reportable'sare					
	Suspected abuse						
	exploitationmi	ssing person, Criminal					

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Event ID: 3RYA11

Facility ID: 000936

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15G422	B. WIN			06/07/2012	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY ALTERNATIV	EQ ANEDT			SHERMAN AVE APOLIS, IN 46220		
					AFOLIS, IN 40220		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLET	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E DATE	
		of unknown origin"		_			
		or dimine with origin					
	On 5/30/12 at 12	:30pm, the facility's					
		and procedure for					
	1	, and Exploitation" was					
	_	licated the following.					
		e: the act or failure to act					
	1 -	uld result in physical					
	injury to an indiv	vidual."					
	-"Verbal Abuse:	the act of insulting or					
	profane language	e or gestures directed					
	toward an individ	dual."					
	-"Emotional/phy	sical neglect: failure to					
	provide goods ar	nd/or services necessary					
	for the individua	l to avoid physical harm."					
	On 5/30/12 at 12	:30pm, the facility's					
	9/14/2007 policy	and procedure for					
	"Investigations"	was reviewed an					
	indicated the foll	owing.					
	-"Ensure alleged	incidents of abuse,					
	_	ment, exploitation, or					
		own origin are fully					
		nin 5 (five) calendar days					
		the allegation was made					
	and investigation						
	_	restigation final report					
		t the completion of the					
	_	he report shall include,					
		I to, the following:					
	•	e allegation or incident.					
		vestigation. Parties					
		nation. Summary of					
	information and	findings, evidence					

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	of Correction identification number: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	5843 N	ADDRESS, CITY, STATE, ZIP CO SHERMAN AVE APOLIS, IN 46220	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	collected, witnesses interviewed, date of the investigation, name of the investigator. Description and chronology of what happenedFinding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated, or inconclusive. Concerns and recommendationsMethods to prevent future incidents (corrective action)." 9-3-2(a)				

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Event ID: 3RYA11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G422	B. WING		06/07/2012	
				ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
NAME OF I	PROVIDER OR SUPPLIEF	t .		N SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		NAPOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0153	The facility must mistreatment, ne injuries of unkno immediately to tl	MENT OF CLIENTS ensure that all allegations of eglect or abuse, as well as wn source, are reported ne administrator or to other dance with State law through edures.				
			W0153	CORRECTION: The facility m	ust 07/07/2012	
	3 of 24 BDDS re of 3 investigation origin and allegal and/or mistreatm #1, #2, #3, #4, #4 failed to immedite Administrator in law allegations of	review and interview, for eports reviewed and for 2 ms of injuries of unknown ations of abuse, neglect, nent reviewed (for clients 5, #6, and #7), the facility ately report to the accordance with state of abuse, neglect, d injuries of unknown		ensure that all allegations of mistreatment, neglect or abus as well as injuries of unknown source, are reported immedia to the administrator or to othe officials in accordance with St law through established procedures. Specifically, a BE Incident report will be submitting regarding staff misuse of a cli #3's library card. Additionally, follow-up reports will be submit to the BDDS regarding the resof investigations into incidents that occurred on 10/17/11 (2), 10/27/11, 12/27/11, 3/25/12, 3/27/12, 4/21/12 and5/15/12.	tely r tate DDS ed ent itted sults	
	(Bureau of Deve Services) reports 12:30pm, the fact reviewed. Both following allegat and/or mistreatm -The 5/16/12 Inv 5/15/12 at 7:30p	om, the facility's BDDS lopmental Disability and on 5/30/12 at sility's investigations were reviews indicated the tions of abuse, neglect, nent: restigation into the m incident indicated ption:" on 5/16/12 at		PREVENTION: Facility professional staff will receive provided with clear expectation regarding reporting, follow-up all required incidents. Facility supervisory staff will be retrain regarding agency reporting procedures, with emphasis or timely completion. Retraining focus on the need to develop maintain sound time management skills and to requestion as needed. Additionally	ns for ned n will and uest	
	7am, clients #1,	#3, and #6 told of the		training will stress the importation of prioritizing facility support to		

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	OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	5843 N	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE IAPOLIS, IN 46220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR 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
	incident to the day shift staff. The description of the incident indicated on 5/15/12 while returning from the library [GHS #6] drove them into an apartment complex in the vicinity of [street #1] and [street #2]." The investigation indicated "During the initial course of the investigation additional allegations emerged suggesting that on the evening of Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out movies for [GHS #6's] personal use and that this resulted in [client #3] incurring late fees of \$9.43." No BDDS report was available of the allegation that GHS #6 used client #3's library card on 5/15/12 and incurred late fees. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. The incident was not reported timely to BDDS. -No BDDS report for this investigation was available for review. An investigation into a 12/27/11 incident indicated client #6 "reported to [GHS #1] on Saturday, 12/24/11 he observed [GHS #7] prevent [client #4] from exiting the bathroom by propping a vacuum cleaner against the bathroom door." The		to assure that alleged violation are reported without delay and that follow-up occurs as require The Quality Assurance and Operations Teams will monitor compliance with reporting timelines and coordinate corrective measures as needed RESPONSIBLE PARTIES: QDDPD, Home Manger, Supprocesses, Operations Teams, Quality Assurance Teams.	ded.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE COMPL		
ANDILAN	OF CORRECTION	15G422	A. BUI	LDING		06/07/	
		130422	B. WIN			00/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			SHERMAN AVE APOLIS, IN 46220		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	"	icated GHS #1 reported					
	the allegation on						
	"	icated GHS #7 had her					
	`	ource) file reviewed					
		GHS #7 "received					
		s: Counseling 8/2/10 for					
		suspected neglect in a					
		n 2/8/11 for failure to					
		eduled, and on 10/17/11					
	"for alleged phys						
	substantiated." 7	•					
	indicated "Concl	usions: The evidence					
	does not substan	tiate that [GHS #7]					
	prevented [client	#4] from exiting the					
	bathroom by pro	pping a vacuum cleaner					
	against the door.	" No evidence was					
	available for revi	ew of notification of the					
	Administrator.						
	-A 10/17/11 BDI	OS report for an incident					
	on 10/17/11 at 4:	45pm, client #6 reported					
		tive staff that "an					
		over the past weekend"					
	_	ed the fire door into his					
		e weekend." The report					
		7 was "suspended					
		tigation." The 10/24/12					
	investigation cor	_					
		rdinator (CC) indicated					
	-	abuse and neglect. The					
		ent #6 and GHS #7's					
	"personalities co						
	_	the the test of th					
		door because "it was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	the same weeken black eye was obstaff on 10/15/11 #4's unknown blauntil 10/17/11. Cinjury and client reported immediand to BDDS. -A 10/17/11 BDI unknown injury 7:20am, indicate red and blue ove swelling. An invital 10/17/11 inciden staff noticed clie eye on 10/15/11 report it until 10/15/11 at 7am, wrong with [clie was not reported Administrator or On 6/1/12 at 10:4 the QMRP (Qual Professional), the Manager (QAM) (QMRP-Designe QMRP indicated BDDS guideline the Administrator	cident. The CC indicated and client #4's unknown asserved by the facility and 10/16/11 and client ack eye was not reported. Client #4's unknown #6's allegation were not ately to the Administrator. OS report for client #4's discovered on 10/17/11 at a d client #4's left eye was a his eye brow with slight estigation into the at for client #6 indicated and 10/16/11 and did not 17/11. GHS #3's witness are when she left on "there was nothing and the was nother to BDDS. 45am, an interview with diffied Mental Retardation are Quality Assurance and the QMRP-D and the completed. The was completed. The the facility followed the sto immediately report to a rallegations of abuse, anistreatment. The QMRP					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G422	A. BUILDING B. WING	COMPLETED 06/07/2012
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION
	and the QAM both indicated staff were trained annually for reporting allegations, incidents, and injuries of unknown origin immediately to BDDS.		
	On 6/1/12 at 10:45am, an interview with the QMRP, QAM, and QMRP-D was completed. The QMRP, QAM, and the QMRP-D stated "some" of the allegations had BDDS reports, and "not all" investigations completed had been reported to BDDS. 9-3-2(a)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE				
		15G422	B. WIN	G		06/07/2	2012
NAME OF P	PROVIDER OR SUPPLIER	3		STREET.	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOIT EIEI				I SHERMAN AVE		
COMMUI	NITY ALTERNATIV	'ES-ADEPT		INDIAN	NAPOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0154	483.420(d)(3)	AENT OF CLIENTS					
	STAFF TREATMENT OF CLIENTS The facility must have evidence that all						
		s are thoroughly investigated.					
	i alleged violation	s are thoroughly lifestigated.	W ₀	154	CORRECTION: The facility m		07/07/2012
			WO	134	have evidence that all alleged		07/07/2012
		view and interview, for 4 of 24			violations are thoroughly		
	,	Developmental Disability			investigated. Specifically,		
		abuse, neglect, and/or			Investigations will be complete	_{ed}	
		ijuries of unknown origin (for #7), the facility failed to			for Client #7's injury of unknown		
		h investigation for allegations			origin on 10/27/11, client #3's		
					suicidal gesture on 3/25/12, C	lient	
	of abuse, neglect, and/or mistreatment and injuries of unknown origin.				#3's elopement incident on		
					3/27/12 and client to client		
	Findings include:				aggression between Client #3		
					and Client #6 on 4/21/12.		
	On 5/29/12 at 4pm,	the facility's BDDS (Bureau of			PREVENTION: Facility		
		ability Services) reports and on			professional staff will receive I		
	_	, the facility's investigations			provided with clear expectatio regarding investigation of	ns	
	were reviewed.				incidents. Facility supervisory		
					staff will be retrained regarding	a	
		report for an incident on			agency investigation procedur	-	
		icated client #6 had reported to			with emphasis on timely		
		aff person on 4/21/12 that client			completion. Retraining will foc	us	
		est and client #6 complained			on the need to develop and		
		ore. No investigation was			maintain sound time		
	available for review	<i>1</i> .			management skills and to requ		
	A 2/21/12 DDDC	an aut Can an in aideast an			assistance from the Operation		
		report for an incident on			Team as needed. Additionally		
		icated client #3 went to the a knife, threatened to hurt			training will stress the importa of prioritizing facility support to		
		a knife, threatened to nurt anded the knife to staff. No			to assure that alleged violation		
		vailable for review for this			are investigated without delay		
	incident.	variable for feview for this			The Quality Assurance and	•	
					Operations Teams will monito	r l	
	-A 3/27/12 BDDS r	report for an incident on			compliance with investigation		
		, indicated client #3 had gone			timelines and coordinate		
		thout Leave) from workshop			corrective measures as neede	ed.	
	· ·	a third time AWOL running			Once completed, the facility w		
		treet #3] into moving traffic			turn in investigation packets to		
	_	nit suicide. No investigation			the Quality Assurance Team f	or	

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Event ID: 3RYA11

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/07/2012	
	ROVIDER OR SUPPLIER		STREET 5843 N	ADDRESS, CITY, STATE, ZIP CODE N SHERMAN AVE NAPOLIS, IN 46220	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	injury discovered or indicated staff found bruise under" client indicated client #7's investigated" and no for review.	report for client #7's unknown in 10/27/11 at 10:15pm, id an unknown "0.75 inch #7's right eye. The report unknown bruise was "being investigation was available		review and filing. Additionally, QDDPD will maintain a copy of each investigation at the facility RESPONSIBLE PARTIES: QDDPD, Home Manger, Supplements of the Associates, Operations Team Quality Assurance Team	of ty.
	QMRP (Qualified M Professional), the Q (QAM), and the QM completed. The QM followed the BDDS allegations of abuse and injuries of unkn the QMRP both ind	m, an interview with the Mental Retardation uality Assurance Manager MRP-D (QMRP-Designee) was MRP indicated the facility guidelines to investigate , neglect, and/or mistreatment sown origin. The QAM and icated no documented ble for review of the			
	QMRP, QAM, and three staff indicated were not thorough be information was do and the QMRP-D st	cumented. The QMRP, QAM, ated "some" allegations had all" investigations completed			
	- (**)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RUILDING 00 COMPLET			ETED	
		15G422	A. BUILDING			06/07/2012	
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
00141411	UT) / ALTEDNIATIV //	EO ADEDT			SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
W0156	The results of all reported to the a representative or	IENT OF CLIENTS investigations must be dministrator or designated r to other officials in State law within five working ent.	W0	156	CORRECTION: The results of	211	07/07/2012
			WU	130	investigations must be reporte		0//0//2012
		review and interview, for			the administrator or designated		
	6 of 24 BDDS (E	Bureau of Developmental			representative or to other office		
	Disability Servic	es) reports reviewed and			in accordance with State law		
	for 2 of 3 investigations reviewed, the				within five working days of the		
	facility failed to	report the results of			incident. Specifically, Follow-u		
	•	cording to State Law			reports will be submitted to the		
	•	g days for clients #1, #2,			BDDS regarding the results of		
	#3, #4, #5, #6, an				investigations into incidents the occurred on 10/17/11 (2),	at	
	#3, #4, #3, #0, a	iu π / .			10/27/11, 12/27/11, 3/25/12,		
	E: 1: : 1 1				3/27/12, 4/21/12 and5/15/12.		
	Findings include	:			PREVENTION: Facility		
					professional staff will receive b	e	
	•	m, the facility's BDDS			provided with clear expectation		
	(Bureau of Deve	lopmental Disability			regarding follow-up reporting for	or	
	Services) reports	and on 5/30/12 at			all required incidents. Facility supervisory staff will be retrain	od	
	12:30pm, the fac	ility's investigations were			regarding agency reporting	Cu	
	reviewed.				procedures, with emphasis on		
					timely completion of follow-up		
	-A 5/16/12 BDD	S report for an incident			reports. Retraining will focus o		
		Opm, indicated when a			the need to develop and maint		
		eported to work (on			sound time management skills		
	•	•			and to request assistance from the Operations Team as neede		
	, -	fold her that on the			Additionally, training will stress		
		when [GHS #6] was			the importance of prioritizing		
		nd his housemates home			facility support tasks to assure		
		(clients #1, #2, #3, #4,			that alleged the results of		
	#5, #6, and #7)sh	ne detoured into an			investigations are reported		
	apartment compl	ex and they observed a			without delay. The Quality		
	man yelling at an	nd hitting a woman who			Assurance and Operations Teams will monitor compliance	,	
	, , , , , , , , , ,	9	I		r reams will monitor compliance	,	ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		15G422	B. WING			06/07/	2012
NAME OF B	DROVIDED OD GUDDU IER		5	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	X.	5843 N SHERMAN AVE				
	NITY ALTERNATIV				APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG			+	TAG	with reporting timelines and		DATE
	was holding a child. [Client #6] alleged				coordinate corrective measure	S	
	-	ot out of the van, left the			as needed. RESPONSIBLE		
		out supervision, and			PARTIES: QDDPD, Home		
		man. [Client #6's]			Manger, Support Associates,		
		oborated his statement.			Operations Team, Quality Assurance Team		
	_	#3, #4, #5, #6, and #7]			ASSULATION LEATER		
		n [GHS #6] was chasing					
		The report indicated staff					
	l * '	gation and GHS #6 was					
	suspended pending an investigation.						
	-The 5/16/12 Investigation into the						
		m incident indicated					
	_	ption:" on 5/16/12 at					
		#3, and #6 told of the					
		ay shift staff. The					
		e incident indicated "On					
	•	turning from the library					
		them into an apartment					
		ricinity of [street #1 and					
		em alone on the van					
	-	intervened in a domestic					
		onally, they said that they					
		nvolved in the dispute					
		Ouring the initial course of					
		additional allegations					
	1	ing that on the evening of					
	0 00						
	Tuesday, 5/15/12, (that) [GHS #6] used [client #3's] library card to check out						
		-					
	-	S #6's] personal use and					
		in [client #3] incurring					
	late fees of \$9.43) .					
	The 5/16/12 Inve	estigation "Conclusion		_			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/07/2012		
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	and Findings" indicated clients #1, #2, #3, #4, #5, #6, and #7 were on the van returning from the library with GHS #6 who took the van into an apartment complex, got out of the van, and left clients unsupervised on the van. The investigation indicated it was verified that client #3 "could not check out items from the library because [client #3] had incurred \$9.43 in late fees" checked out by GHS #6 for GHS #6's personal use. The investigation conclusion indicated "The evidence substantiates that the actions [GHS #6] resulted in the individuals who lived [in the group home] experiencing mental anguish." The results of the investigation were not reported to BDDS within five (5) working days. -A 4/22/12 BDDS report for an incident on 4/22/12 at 8am, indicated client #6 had reported to facility staff to a staff person on 4/21/12 that client #3 hit him in the chest and client #6 complained that his chest was sore. No results of the investigation were reported to BDDS. -A 3/31/12 BDDS report for an incident on 3/25/12 at 9am, indicated client #3 went to the kitchen, "grabbed" a knife, threatened to hurt herself, and later handed the knife to staff. The results of					
	the investigation were not reported to					

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Event ID: 3RYA11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE (COMPL		
		15G422		LDING		06/07/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	_ ` ` ·			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		*		TAG	DEFICIENCY)		DATE
	BDDS Within fiv	ve (5) working days.					
	An investigation	n into a 12/27/11 incident					
		n into a 12/27/11 incident f6 "reported to [GHS #1]					
		24/11 he observed [GHS					
	I	nt #4] from exiting the					
	3.4	pping a vacuum cleaner					
	against the bathr						
	~	icated GHS #1 reported					
	the allegation on	•					
investigation indicated GHS #7 had her HR (Human Resource) file reviewed							
	`	GHS #7 "received					
		s: Counseling 8/2/10 for					
		suspected neglect in a					
		on 2/8/11 for failure to					
		eduled, and on 10/17/11					
	"for alleged phys						
		The investigation					
		usions: The evidence					
		tiate that [GHS #7]					
		: #4] from exiting the					
	_ ~	pping a vacuum cleaner					
		" The results of the					
	_						
	~	re not reported to BDDS					
	within five (5) w	orking days.					
	_A 10/27/11 DD	DS report for client #7's					
		discovered on 10/27/11 at					
	" "	ted staff found an					
	_	nch bruise under" client					
	1	he report indicated client					
	#7's unknown br	_					
	investigated." T	ne results of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422			LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		p. wii.	STREET A	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	within five (5) w	re not reported to BDDS orking days.					
	on 10/17/11 at 4: to the administra unspecified time GHS #7 "slammed buttocks over the indicated GHS # pending an investigation cor Compliance Coorunsubstantiated at CC indicated client # fell into the fire of unwitnessed" incompliance was obstaff on 10/15/11 #4's unknown blauntil 10/17/11. The investigation were within five (5) where the control of the same weeker was obstaff on 10/15/11 #4's unknown blauntil 10/17/11. The investigation were within five (5) where the control of th	rdinator (CC) indicated abuse and neglect. The ent #6 and GHS #7's inflict." The CC #6 hit, bumped into, or door because "it was eident. The CC indicated and client #4's unknown observed by the facility and 10/16/11 and client ack eye was not reported. The results of the re not reported to BDDS orking days. DS report for client #4's discovered on 10/17/11 at discovered on 10/17/11 at discovered on the results of the graph of the results					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPLI		
		15G422	B. WIN			06/07/	2012
	ROVIDER OR SUPPLIER			5843 N	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220		
			1	<u> </u>	711 0210, 111 10220	ı	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		eye on 10/15/11 and					
		I not report it until					
		#3's witness statement					
		she left on 10/15/11 at					
		nothing wrong with					
	[client #4's] eye.	" The results of the					
	_	re not reported to BDDS					
	within five (5) w	vorking days.					
	On 6/1/12 at 10:	45am, an interview with					
		lified Mental Retardation					
	Professional), the Quality Assurance						
	, ·), and the QMRP-D					
		ee) was completed. The					
		I the facility followed the					
	-	s to investigate and to					
	_	of the completed					
	•	the Administrator within					
	_	days for allegations of					
		nd/or mistreatment. The					
	_	MRP both indicated no					
		dence was available for					
		ing the results of the					
	investigations.	ing the results of the					
	in vestigations.						
	On 6/1/12 at 10:	45am, an interview with					
		M, and QMRP-D was					
	, , ,	QMRP, QAM, and the					
	•	"some" allegations had					
		not all" investigations					
	-	een reported to BDDS,					
	•	investigations had been					
		five (5) working days.					
	Toported within	in (5) morning days.					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CC A. BUILDING B. WING	00				
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	9-3-2(a)							

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Facility ID: 000936

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		15G422	B. WIN	G		06/07/2	2012
	PROVIDER OR SUPPLIER			5843 N	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE IAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0157	483.420(d)(4) STAFF TREATM If the alleged viol corrective action Based on record 5 of 24 BDDS (EDisability Service 2 of 3 investigating facility failed to corrective action origin and allegation and allegation and allegation origin and allegation of abuse mistreatment. Finding include: On 5/29/12 at 4p (Bureau of Developments	TENT OF CLIENTS lation is verified, appropriate	WO		CORRECTION: If the alleged violation is verified, appropriate corrective action must be take. Specifically, direct support staff #6's employment has been terminated and the facility has added additional direct suppor staff on evenings and weekend to increase supervision and supplement active treatment services. PREVENTION: The Quality Assurance team will review investigation results an interdisciplinary team meeting records, and will follow-up as needed with facility supervisor staff and the Operations Team assure the facility implements corrective measures as neede RESPONSIBLE PARTIES: QDDPD, Home Manger, Supp Associates, Operations Team, Quality Assurance Team	n. ff t ds d	07/07/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		15G422	B. WIN			06/07/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
00044411		EQ ADEDT			SHERMAN AVE	
СОММО	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
TAG		(clients #1, #2, #3, #4,		TAG	BETTELLINETY	DATE
	1					
		he detoured into an				
		ex and they observed a nd hitting a woman who				
		ild. [Client #6] alleged				
	_	ot out of the van, left the				
	1 2 30	out supervision, and				
		man. [Client #6's]				
		oborated his statement.				
	[Clients #1, #2, #3, #4, #5, #6, and #7]					
	indicated the man [GHS #6] was chasing had a firearm." The report indicated staff					
		gation and GHS #6 was				
	1 ^	ng an investigation.				
	suspended pendi	ng an mvestigation.				
	-The 5/16/12 Inv	restigation into the				
	5/15/12 at 7:30pr	m incident indicated				
	"Incident Descrip	ption:" on 5/16/12 at				
	7am, clients #1,	#3, and #6 told of the				
	incident to the da	ay shift staff. The				
	description of the	e incident indicated "On				
	5/15/12 while ret	turning from the library				
	[GHS #6] drove	them into an apartment				
	complex in the v	icinity of [street #1] and				
	[street #2] and le	ft them alone on the van				
	while [GHS #6]	intervened in a domestic				
	dispute. Additio	nally, they said that they				
	believed a man in	nvolved in the dispute				
	had a firearm. D	ouring the initial course of				
	the investigation	additional allegations				
	emerged suggest	ing that on the evening of				
	Tuesday, 5/15/12	2, (that) [GHS #6] used				
	[client #3's] libra	ry card to check out				
	movies for [GHS	S #6's] personal use and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	
		15G422	B. WIN			06/07/2	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY ALTERNATIV	FS-ADEPT			SHERMAN AVE APOLIS, IN 46220		
			-	l			
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	that this resulted	in [client #3] incurring					
	late fees of \$9.43						
	The 5/16/12 Inve	estigation for the 5/15/12					
	incident indicate	d the following witness					
	statements:						
	-Client #3 stated	"On our way home,					
	[GHS #6] took u	s to some apartments.					
	[GHS #6] got ou	t of the van and ran up to					
	the apartment an	d left us by ourselves.					
She went after this guy who hit the girl							
	with the baby in	her hand. The police					
	"	was calling [GHS #6] a					
		after him and was cussing					
	at him and yellin	•					
	_	ound [street #1] and					
		e police came. [GHS #6]					
		n but I didn't see any gun.					
		shots. [GHS #6] left us					
		The guy called her a b					
	- and said he wo	uld shoot her."					
		'I worked by myself. I					
	'	myself. We went to the					
	1 -	er. We were there about					
		lfI didn't check					
		t day. On my way to the					
		I had left one of the					
	<u>-</u>	the counter so I had to go					
		round in an apartment					
		a man and a lady with a					
		le was actually beating on					
		n't fighting back. I did					
	stop and say som	nething to them and told					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
	15G422	A. BUILDING		06/07/2012
	<u> </u>	B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		SHERMAN AVE	
СОММИ	NITY ALTERNATIVES-ADEPT	INDIAN	APOLIS, IN 46220	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	them I was going to call the police and I	TAG	BLITCLERCTY	DATE
	did call the policeI got out on the side of			
	the van. I didn't leave the van. I said Hey			
	that is child endangerment and I'm calling			
	the policeBefore the police came, they			
	went into the apartment building so the			
	police couldn't go in after them because			
	they didn't know where they lived. The			
	man did not have a weapon. I wouldn't			
	have got out of the van if there was a			
	weaponThe guy was cussing me out			
	saying I'll shoot you. He was mad			
	because I stopped him from doing			
	something he shouldn't have been			
	doing"			
	The 5/16/12 Investigation "Conclusion			
	and Findings" indicated clients #1, #2, #3,			
	#4, #5, #6, and #7 were on the van			
	returning from the library with GHS #6			
	who took the van into an apartment			
	complex, got out of the van, and left			
	clients unsupervised on the van. The			
	investigation indicated it was verified that			
	client #3 "could not check out items from			
	the library because [client #3] had			
	incurred \$9.43 in late fees" checked out			
	by GHS #6 for GHS #6's personal use.			
	The investigation conclusion indicated "The evidence substantiates that the			
	actions [GHS #6] resulted in the			
	individuals who lived [in the group home]			
	experiencing mental anguish." No			
	corrective action was available for review.			
	corrective action was available for feview.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	COMPLETED		
		15G422	B. WIN	G		06/07/2012	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	GHS #6 was sus	pended since 5/16/12.					
	A 2/21/12 DDD						
		S report for an incident					
		m, indicated client #3					
		en, "grabbed" a knife,					
		t herself, and later					
		to staff. No corrective					
		nt reporting was available					
	for review.						
	A 2/27/12 DDD	C					
		S report for an incident					
		25am, indicated client #3					
		(Absent Without Leave)					
	_	wice, client #3 left a third					
		ning into traffic down					
		noving traffic threatening					
		e. The corrective action					
		d not returned to day					
		op since incident. No					
		lence was available for					
		#3's ISP and BSP					
	1 -	#3's threats of suicide					
	into moving traff	fic.					
	_	n into a 12/27/11 incident					
		#6 "reported to [GHS #1]					
	1	24/11 he observed [GHS					
		nt #4] from exiting the					
		pping a vacuum cleaner					
	against the bathr						
	investigation ind	icated GHS #1 reported					
	the allegation on	12/27/11. The					
	investigation ind	icated GHS #7 had her					
	HR (Human Res	ource) file reviewed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 06/07/2012				
		15G422	B. WING			06/07/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
CONANALII	NUTY ALTERNATIV	EC ADEDT			SHERMAN AVE		
	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
TAG		GHS #7 "received		IAG			DATE
		s": Counseling 8/2/10 for					
		· ·					
		suspected neglect in a on 2/8/11 for failure to					
	<u>-</u>	eduled, and on 10/17/11					
	"for alleged phys	·					
		The investigation					
		usions: The evidence					
		tiate that [GHS #7]					
		#4] from exiting the					
	^ ~	pping a vacuum cleaner					
		" No corrective action					
	_	review for reporting					
		use, neglect, and/or					
	mistreatment im						
	administrator.	inediately to the					
	administrator.						
	 -A 10/17/11 BDI	DS report for an incident					
		:45pm, client #6 reported					
		tive staff that "an					
		over the past weekend"					
		ed the fire door into his					
		e weekend." The report					
		7 was "suspended					
		stigation." The 10/24/11					
	investigation cor	_					
	_	ordinator (CC) and					
	_	tantiated abuse and					
		indicated client #6 and					
	_	nalities conflict." The					
	_	ent #6 hit, bumped into,					
		re door because "it was					
		eident. The CC indicated					
		nd client #4's unknown					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G422		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	staff on 10/15/11 #4's unknown bla until 10/17/12. N available for revi allegations of abi mistreatment ima administrator. -A 10/17/11 BDI unknown injury 7:20am, indicate red and blue ove swelling. An alle the 10/17/11 inci indicated staff no unknown black of 10/16/11 and did 10/17/11. GHS of indicated when so 7am, "there was [client #4's] eye.' was available for allegations of abi mistreatment ima administrator. On 6/1/12 at 10:2 the QMRP (Qual Professional), the Manager (QAM) (QMRP-Designe QAM stated corr	DS report for client #4's discovered on 10/17/11 at d client #4's left eye was r his eye brow with slight egation investigation into dent for client #6 oticed client #4's eye on 10/15/11 and not report it until #3's witness statement he left on 10/15/11 at nothing wrong with review for reporting use, neglect, and/or					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
MIDILAN	15G422	A. BUILDING		06/07/2012
	100122	B. WING	DDDECC CITY CTATE OF CORE	30/01/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE	
СОММИ	NITY ALTERNATIVES-ADEPT		APOLIS, IN 46220	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	able to substantiate the allegation. The			
	QMRP and the QAM both indicated staff			
	were trained annually for reporting allegations and injuries of unknown			
	origin. The QAM and the QMRP both			
	indicated no documented evidence was			
	available for review of completed			
	corrective action for staff to immediately			
	report to the administrator allegations of			
	abuse, neglect, and/or mistreatment.			
	On 6/1/12 at 10:45am, an interview with			
	the QMRP, QAM, and QMRP-D was			
	completed. The QMRP, QAM, and the			
	QMRP-D stated "some" allegations had			
	BDDS reports, "not all" investigations			
	completed had been reported to BDDS,			
	no results of investigations had been			
	reported, and no documented corrective			
	action to ensure staff immediately			
	reported to the administrator allegations			
	of abuse, neglect, and/or mistreatment and			
	injuries of unknown origin. The QAM			
	stated GHS #6 "was still suspended at this			
	time (6/1/12)." QAM indicated client #3			
	was reimbursed the \$9.43 for late fees			
	from her library card exploitation and			
	indicated no documented receipt was available for review.			
	available for review.			
	9-3-2(a)			
	•	•		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED		
		15G422	B. WIN		06/		6/07/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE			
COMMUN	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46220			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRE			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0159	PROFESSIONAl Each client's acti be integrated, co	NTAL RETARDATION L Ive treatment program must ordinated and monitored by al retardation professional.						
		,	W0	159	CORRECTION: Each client's		07/07/2012	
	Based on observa	ation, interview, and		10)	active treatment program must integrated, coordinated and	t be	0,,0,,2012	
	record review, for	or 4 of 4 sample clients			monitored by a qualified menta	a/ I		
	-	3, and #4) and for three			retardation professional.			
	` '	s (clients #5, #6, and #7),			Specifically, the QDDPD will			
		lified Mental Retardation			receive additional training on the following topics: 1.Completion of accurate reassessments of client's			
	•							
	` ~	MRP) failed to integrate,						
		nonitor the development			vocational needs for upon changes in employment status			
	of training progra	ams to ensure the			2.The need to develop beha			
	Individual Suppo	ort Plans (ISPs) were			supports across environments			
	based on identific	ed needs, assessments,			address all behavioral needs. 3.Development of appropriat	-		
	comprehensive f	unctional assessments			training objectives for clients	.6		
	(CFAs), and prog	gram data recorded. The			based on their needs.			
	QMRP failed to	ensure each client's ISP			 4.Encouraging and including client choices for food. 			
	was implemented	d when opportunities			5.Implementation of client #3	3's		
	existed.				behavior plan and providing			
	Findings include	:			supervision during formal and informal opportunities for training. 6.Ensuring accurate behavior data is recorded for Client #3. 7.Obtaining approval from the			
	1. Please refer to	W225. The facility			facility's Human Rights			
	failed to complet	•			Committee (HRC) for all			
	*	client #3's vocational			restrictive practices 8.Encouraging clients to use			
		sample client (client #3)			adaptive equipment and trainir			
		ith no current workshop services.			and monitoring staff to assure	·9		
	with no current v	Torkshop services.			adaptive equipment learning			
	2 DI 2	NIOGO TIL C. TIL			objectives are implemented			
	2. Please refer to	W227. The facility			consistently, as well as the nee	ed		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/07/2012	
	PROVIDER OR SUPPLIEI	1	5843 N	ADDRESS, CITY, STATE, ZIP COE SHERMAN AVE JAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
	failed for 1 addinaddress his behapop, and food at 3. Please refer to failed to develop based on client #4 sample clients 4. Please refer to failed to encourachoices for food #1, #2, #3, #4, #1 in the group hon 5. Please refer to failed to implement plan and provide formal and informal and information (client #3).	tional client (client #5) to viors of theft of money, the workshop. o W242. The facility of a training objective/goal #2's toileting need for 1 of (client #2). o W247. The facility age and include client for 7 of 7 clients (clients 5, #6, and #7) who lived he. o W249. The facility dent client #3's behavior the supervision during mal opportunities when listed for 1 of 4 sample		to maintain adaptive equincluding, but not limited walkers, in good repair. 9. Conducting monthly/review of ISP/BSP data. 10. Assuring staff collect behavioral data as needed PREVENTION: Member Operations and Quality Assurance Teams will coperiodic audits of facility documents and conduct treatment observations of ongoing basis to assure QDDPD integrates, coordinated monitors, the active treatment program effect will provide guidance, meand corrective measures needed. RESPONSIBLI PARTIES: QDDPD, Oper Team, Quality Assurance	ipment to quarterly ts ed. ers of the enduct support active en an the dinates ively and entorship as E erations
	failed obtain app	o W264. The facility broval from the facility's Committee (HRC) for			

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MU	JETIPLE CO.	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	15G422	A. BUIL		00	06/07/	
		100 122	B. WING		DDDEGG CITY OT ATE TID CODE	00/01/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ces employed for 7 of 7		IAG			DATE
	*	1, #2, #3, #4, #5, #6, and					
	#7) who lived in						
	#7) who hved in	the group nome.					
	8. Please refer to	W436. The facility					
failed to teach and encourage client #1 to							
	wear his prescrib	ped eye glasses, client #2					
	_	ng aid and prescribed eye					
		to wear her prescribed					
	eye glasses, and failed to provide client						
	, ,	ir for 3 of 4 sample					
	_	1, #2, and #3) and 1					
		(client #6) who had					
	adaptive equipme						
	daptive equipm	ent preserioed.					
	9. On 5/31/12 at	11am, client #1's					
	3/22/12 ISP (Ind	ividual Support Plan) and					
	record for the cu	rrent year were reviewed.					
	Client #1's record	d did not indicate a					
	quarterly review	of client #1's record or					
	ISP by the QMR	P. Client #1's record did					
	not indicate prog	ram data reviews and did					
	not indicate beha	vioral data.					
		50pm, client #2's 10/2/11					
		or the current year were					
		t #2's record did not					
	•	rly review of client #2's					
	-	the QMRP. Client #2's dicate program data					
	record and not in	uicaie program data					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	5843 N	NDDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	reviews and did not indicate behavioral data.			
	On 5/31/12 at 11:20am, client #3's 4/27/12 ISP and record were reviewed and did not indicate a quarterly review of client #3's record by the QMRP, did not indicate program data, and did not indicate behavioral data. On 5/31/12 at 12:35pm, client #4's 8/28/11 ISP and record for the current year were reviewed. Client #4's record did not indicate a quarterly review of client #4's record did not indicate a program data reviews and did not indicate program data reviews and did not indicate behavioral data. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated no quarterly QMRP reviews for clients #1, #2, #3, and #4 were available for review. The QMRP indicated no program data was available for review of client #1, #2, #3, and #4's programs. The QMRP indicated no additional information was available for review.			
	, , , , , , , , , , , , , , , , , , ,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 06/07/2012			
	PROVIDER OR SUPPLIER		5843	T ADDRESS, CITY, STATE, ZIP CODE N SHERMAN AVE NAPOLIS, IN 46220	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
W0186	483.430(d)(1-2) DIRECT CARE The facility must staff to manage accordance with plans. Direct care staff on-duty staff cale 24-hour period for living unit. Based on record 7 of 7 clients (cl. #6, and #7) who the facility failed on duty to superidentified needs. Findings include On 5/29/12 from and on 5/30/12 from and on 5/30/12 from and on 5/30/12 from and on 5/30/12 from 6:50pm units the both periods two were observed in from 6:50pm units the was open/down, extended outward 6:50pm until 7:1 unsupervised by observed to load	STAFF It provide sufficient direct care and supervise clients in their individual program are defined as the present culated over all shifts in a or each defined residential review and interview, for itents #1, #2, #3, #4, #5, lived in the group home, diento provide enough staff vise clients based on their	W0186	CORRECTION: The facility in provide sufficient direct care to manage and supervise clie in accordance with their indiv program plans. Specifically, the facility has added additional of support staff on evenings and weekends to increase supervand supplement active treatm services. PREVENTION: The Operations Team will monitor facility staff schedules to assuadequate direct support staff assigned to all shifts. Addition on an ongoing basis, member the Operations and Quality Assurance Teams will spot of time and attendance records assure hours worked match the facility schedule. RESPONSIBLE PARTIES: QDDPD, Home Manger, Sup Associates, Operations Team Quality Assurance Team	oust staff ents idual he direct d crision ment me are mally, rs of meck to he port

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422			LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	5843 N	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	5/30/12 from 5:2 two large butche the open dishwas extended and expuntil 8:20am, clicindependent acceptate butcher knives in On 5/29/12 at 6:2 her bedroom in the front door from bedroom door slight slammed, it reopout the front doo and no facility stracility van was windows to the follocking the view windows into the walked across the near the road in the and sat down. Concigarettes and light At 6:30pm, the Form of the client #3 "goes of independently." I leaves AWOL from 6:35pm, the RM spoke with client the swing. At 6:43 returned inside the swing.	nen four (4) times. On 5am until 8:20am, the r knives were observed in sher with the utensil rack bosed. From 5:25am ent #3 had unsupervised ess to the two large in the utensil rack. 20pm, client #3 ran into the front of the house near om the kitchen and the ammed. Just as the door ened and client #3 was r into the front yard alone aff followed her. The parked in front of the front living room w from the living room e front yard. Client #3 the front yard to the swing front of the group home lient #3 pulled out her sher and began to smoke. Residential Manager the door. The RM stated tut there to smoke" The RM stated "she only om workshop." At walked outside and the #3 who sat smoking on 40pm, the RM and client the the group home. At stated client #3's level of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
	PROVIDER OR SUPPLIER		P . W.E.	STREET A	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	supervision was every so often."	"we just keep track of her					
	5/31/12 at 11:20a indicated client # facility on 2/201: BSP (behavior su targeted behavior physical aggress: "AWOL defined [client #3] is very about an issue or her way. [client # premises unsupe (which is) any time implicating that and that she has at therefore she war #3's 3/13/12 BSF and Suicidal Threat to "Keep [client is times when she I home/property," document AWO The plan did not staffperson was taline of sight whill #1, #2, #4, #5, #6 On 5/31/12 at 11 4/2012, and 3/20 Sheet" were revised.	rvised, Suicidal Threats me [client #3] starts mobody cares about her mothing to live for, mts to kill herself." Client rindicated for AWOL eats behaviors staff were #3] in your sight at all eaves the offer activity, and L incident and behaviors. indicate how one o monitor client #3 in e still supervising clients 5 and #7. am, the facility's 5/2012, 12 "Staff Schedule					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		15G422	B. WING			06/07/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
00040411		VEC ADEDT			SHERMAN AVE		
COMMO	NITY ALTERNATI\	/ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG				TAG	Dirichi.(C.)		DATE
		aff person 7am until 3pm,					
	_	2pm until 10pm, one					
		om until 8am. The staff attached for Saturdays and					
		•					
	_	aff person 6am until 10pm rson from 10pm until					
	1	rson from ropin until					
	8am.						
	On 5/20/12 of 1	2.45nm on intorvious with					
		2:45pm, an interview with urance Manager (QAM)					
		D (Qualified Mental					
	`	fessional-Designee) was					
		• ,					
	•	h indicated one staff was					
		even clients (clients #1,					
		6, and #7). The QAM					
		funds this house at 6.0					
		as one staff on duty for					
		The QMRP-D and the					
		ed clients #1, #2, #3, #4,					
		required" staff supervision					
	for cooking, act						
	_	and clients #1, #2, #4, #5,					
	_	d" assistance in bathing					
		oth the QAM and the					
	-	clients #2 and #7					
	_	tance with toileting needs.					
	_	QMRP-D both stated					
		ye sight supervision at all					
	times."						
	On 6/1/12 at 10	·15am on intomious with					
		:45am, an interview with					
	, , ,	alified Mental Retardation					
	, ·	ne Quality Assurance					
	Manager (QAM), and the QMRP-D					

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	of Correction identification number: 15G422	A. BUILDING B. WING	00	COMPI	
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	5843 N	ADDRESS, CITY, STATE, ZIP C SHERMAN AVE APOLIS, IN 46220	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	(QMRP-Designee) was completed. The QAM stated there was "always one staff" for seven clients in the group home. The QMRP and the QAM stated the agency had reviewed their staffing plan for the group home and was "going to add" staff. 9-3-3(a)				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G422	B. WIN			06/07/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUN	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
W0225	483.440(c)(3)(v) INDIVIDUAL PR	OCDANA DI ANI					
	•	sive functional assessment					
	must include, as applicable, vocational skills. Based on record review and interview, for		Wo	225	CORRECTION: The		07/07/2012
			** 0.	223	comprehensive functional		07/07/2012
	•	ent (client #3) with no			assessment must include, as		
		services, the facility			applicable, vocational skills.		
	•	e a reassessment of client			Specifically, the team will		
	#3's vocational n	eeds.			complete a re-assessment of		
				Client #3's vocational skills an needs. PREVENTION:		d	
	Findings include:		Professional staff will be retrained				
					regarding the need to assure t		
	On 5/29/12 from	5:25pm until 7:15pm,			in additional to annual	iiat,	
		rom 5:25am until			reassessment, the team must		
		tions and interview were			reassess vocational needs wh	en	
		group home. During			a client's vocational or day		
	•	• .			service status changes	•	
	•	nt #3 indicated she did			unexpectedly. Members of the Operations and Quality	1	
	_	end work services. Client			Assurance Teams will periodic	cally	
		ng both observation			review facility support docume		
	*	not attended workshop			on an ongoing basis to assure		
	since March, 201	2.			that the team meets clients'		
					vocational training needs		
	Client #3's record	d was reviewed on			RESPONSIBLE PARTIES: QDDPD, Home Manger, Supp	ort	
	5/31/12 at 11:20a	am. Client #3's record			Associates, Operations Team,		
	indicated client #	[‡] 3 was admitted to the			Quality Assurance Team		
	facility on 2/2012	2. Client 3's 4/22/12					
	_	ort Plan (ISP) included an					
		schedule which indicated					
		h Fridays "from 7:30am -					
		shop, from 7:30am to					
		•					
	4pm [Workshop name]from 4pm to 5pm ride home from workshop." Client						
	•	•					
	#3's 2/24/12 "Vo						
	assessment indic	ated client #3 was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED	
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT	INDIAN	APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL 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
	In-seat behavior, Dexterity Skills, Eye-Hand Coord Instructions, Use Matches colors, Additional record reassessment for needs was comples suspended from On 6/1/12 from 8 Workshop Site # client #3 was not At 8:55am, WKS was interviewed. was client #3's su #3's workshop se 3/2012. WKS #3 great worker, gre #3] was not havi indicated client # were suspended behaviors of AW Leave) and runni stated "we have to workshop could At 9:15am, WKS client #3 left AW she was "manic" stating "she want 9:45am, WKS #3 would like client	Discrimination Skills, lination, Follows s Pincher Grasp, (and) Concept on One." d review indicated no client #3's vocational leted after client #3 was				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE (COMPL		
ANDILAN	OF CORRECTION	15G422	A. BUI	LDING	00	06/07/	
		130422	B. WIN			00/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			SHERMAN AVE APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	client #3 safe at work.					
		when client #3 "gets like					
	_	‡3] does not recognize					
	_	eve she was not safe at					
		indicated no plan was					
		iew and had not been					
	_	p client #3 safe at work.					
	WKS #1 provide	ed the following team					
	meeting minutes	without client #3					
	present: On 4/26	5/12, "Team met to					
	discuss what plan	ns can be put into [client					
	#3's] safety while	e not providing one on					
	one supervision l	beyond a reasonable					
	amount of time.	Self Harm, Elopement,					
	[client #3's stater	nents of] Nobody Cares,					
	Result in contact	ing home, [client #3] will					
	go home." WKS	#1 indicated the					
	workshop leaders	ship reviewed this plan					
	and the workshop	p leadership did not					
	believe this went	far enough to keep client					
	#3 safe and the w	vorkshop employees safe.					
	WKS #1 stated "	She's not coming until					
	something can be	e figured out." Client					
	#3's workshop be	ehavior data and incident					
	records were req	uested from 2/2012					
	through 5/31/12.	WKS #1 stated client					
	#3's behavioral d	ata from workshop was					
	not available for	review. WKS #1					
	provided client #	3's workshop data sheets					
	_	umentation dated 2/2012,					
		and 5/2012. All four (4)					
		ocument client #3's					
		e information indicated					
		attended workshop since					
		•					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		15G422		LDING		06/07/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3/20/12.						
	0 6/4/4						
		45am, an interview with					
	the Qualified Me						
		MRP) was completed.					
		eated client #3 had					
		nd leaving the workshop 2. The QMRP indicated					
		hop services had been					
		QMRP indicated client					
	-						
	#3 had no reassessment for her vocational needs completed since 2/2012.						
	needs completed	5111CC 2/2012.					
	9-3-4(a)						
) J !(u)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SUI	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI III	DDIC	00	COMPLET	ED
		15G422	A. BUII			06/07/20	12
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
		50 ADEDT			SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0227	483.440(c)(4)						
	INDIVIDUAL PR	OGRAM PLAN					
	The individual pr	ogram plan states the					
	specific objective	es necessary to meet the					
	client's needs, as	s identified by the					
	comprehensive a	assessment required by					
	paragraph (c)(3)	of this section.					
			W0:	227	CORRECTION: The individual		07/07/2012
	Based on observation	on, record review, and			program plan states the specif	ic I	
		itional client (client #5), the			objectives necessary to meet		
		lress client #5's behaviors of			client's needs, as identified by	the	
		, and food at the workshop.			comprehensive assessment.		
	their of money, pop	, and rood at the workshop.			Specifically, the team will deve	elop	
	Findings include:				appropriate behavior supports	to	
	r manigs metade.				address Client #5's stealing		
	On 5/20/12 from 10	:10am until 11:02am, client #5			money,soft drinks and food at	the	
		rkshop site #1. From 10:10am			workshop. PREVENTION :		
		t #5 watched a movie, walked			Facility professional staff will b	e	
		area independently, and at			retrained regarding the need to		
		ogram area to go to the rest			develop comprehensive behav		
	_	client #5's workshop			supports across environments	for	
		client #5's ISP (Individual			all clients. Members of the		
	*	objective was to use money in			Operations and Quality		
		e to obtain his desired items.			Assurance Teams will periodic	-	
	_	rvisor stated "He never has any			review incident documentation		
		oal." The workshop supervisor			and support documents, on ar		
		l take other clients' food, pop,			ongoing basis to assure the te	am	
		on a regular basis." The			addresses client behavioral		
		r indicated client #5 had no			support needs as appropriate.		
		or Support Plan. The			(Addendum, 6/29/12: The Hor	me	
		r stated "This behavior is not			Manager and QDDPD will		
	* *	been doing this "a long time.			conduct on-site observations a	IT	
		me know about the behaviors."			day service and workshop		
	The workshop super				facilities no less than monthly.		
		of client #5's behaviors of			Additionally, the facility has be using communication noteboo		
		pop, and snacks was available			for each client to enable	NO	
		0am, client #5 was observed to			residential and day service sta	ff	
		after entering, walked through			to communicate about issues		
		_			they arise on a daily basis.)	40	
	_	ng to the front break area, and			RESPONSIBLE PARTIES:		
	_	heck the change return slots in			QDDPD, Home Manger, Supp	ort	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G422		IBER:	A. BUILDING B. WING			COMPLETED 06/07/2012	
	ROVIDER OR SUPPLIER	_	5843 N S	DDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIE (EACH DEFICIENCY MUST BE PERCEDE REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	supervisor stated client #5 "will go through trash and lunch boxes to get pop or mone Client #5 located three workshop clients the break area, walked around to circle the tables, and eyed their snacks and pop on tables. Client #5 opened the trash can lidinside, removed a empty can, and was obshake it. On 5/31/12 at 1:50pm, client #5's record reviewed and no Behavior Support Plan (was available for review. Client #5's 10/(Individual Support Plan) did not indicate behaviors of the theft of money, pop, or for the workshop. On 5/31/12 at 10:45am, an interview was completed with the QMRP. The QMRP client #5 had no Behavior Support Plan a for review. 9-3-4(a)	sitting in heir the ls, looked served to was (BSP) 14/11 ISP e the Good at		Associates, Operations Team, Quality Assurance Team			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		15G422	A. BUII B. WIN			06/07/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T.E.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
W0242	those clients who personal skills es independence (ir toilet training, pe hygiene, self-fee grooming, and coneeds), until it has the client is deve acquiring them. Based on observating interview, for 1 cm #2), the facility for training objective #2's toileting needs. Findings include On 5/29/12 from and on 5/30/12 from and on 5/30/12 from and the bathroom. Do periods client #2 briefs sitting insition the floor beside 5/30/12 at 6:30 are to wear slacks an stuck out from the Client #2's recore 5/31/12 at 1:50 principles.	ogram plan must include, for a lack them, training in sential for privacy and including, but not limited to, resonal hygiene, dental ding, bathing, dressing, ommunication of basic as been demonstrated that elopmentally incapable of ation, record review, and of 4 sample clients (client failed to develop a elogal based on client id. 5:25pm until 7:15pm, rom 5:25am until 2 walked throughout the was not observed to use uring both observation had adult incontinent de her shared bedroom de her dresser. On m, client #2 was observed ad the incontinent brief	Wo	242	CORRECTION: The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but in limited to, toilet training, person hygiene, dental hygiene, self-feeding, bathing, dressing grooming, and communication basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Specifically, the team has initiated a learning objective that addresses Clien #2's toileting needs PREVENTION: The QDDPD to be retrained regarding the need to review the comprehensive functional assessment, incider documentation and progress notes to assure each client receives training in needed personal skills. Members of the Quality Assurance and Operations Teams will periodically compare current support documents to assessment data to assure	not nal , , of ne t will nt	07/07/2012

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	OF CORRECTION OF CORRECTION 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER	5843 N	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE JAPOLIS, IN 46220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	hands independently after toileting. Client #2's 4/15/12 "Physician Orders" indicated "May use Depends type undergarments as needed." Client #2's 10/2/11 entry from her vocational location indicated "depends at work due to incontinence." No toileting goal was available for review. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional), the QMRP-D (Qualified Mental Retardation Professional-Designee), and the Director of Quality Assurance (DQA) was completed. The three professional staff indicated client #2 was incontinent and wore incontinent briefs for client #2's dignity. The QMRP indicated client #2 did not have a specific objective which taught client #2 to use the toilet. 9-3-4(a)		training needs are addressed each client's individual supported plan. RESPONSIBLE PART QDDPD, Home Manger, Sup Associates, Operations Team Quality Assurance Team	in rt IES: port

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		15G422	B. WIN			06/07/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		5843 N SHERMAN AVE				
COMMUI	NITY ALTERNATIV	ES-ADEPT	INDIANAPOLIS, IN 46220				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W0247	483.440(c)(6)(vi) INDIVIDUAL PR The individual pr opportunities for self-management Based on observation interview, for 7 of #2, #3, #4, #5, #6 the group home, encourage and infood. Findings include: On 5/29/12 at 6pm, and #7 sat down to of included salad and of Italian." On 5/30/12 at 7:50a #6, and #7 sat down which included one On 6/1/12 at 10:45a QMRP (Qualified M	OGRAM PLAN ogram plan must include client choice and it. ation, record review, and of 7 clients (clients #1, 6, and #7) who lived in the facility failed to aclude client choices for clients #1, #2, #3, #4, #5, #6, eat the evening meal which one salad dressing "Zesty m, clients #1, #2, #3, #4, #5, to eat the breakfast meal cereal "Frosted Cheerios."	W0:		CORRECTION: The individual program plan must include opportunities for client choice self-management. Specifically direct support staff will be retrained regarding the need to offer appropriate mealtime choices including but not limite to condiments. PREVENTIOI Facility professional staff will be expected to observe no less the two morning and two evening active treatment sessions per week to assure staff support dietary choices. Additionally members of the Operations ar Quality Assurance Teams will periodically monitor active treatment on an ongoing basis assure quality meal time service delivery. RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates,	and o ed N: be nan	07/07/2012
	indicated clients #1,	#2, #3, #4, #5, #6, and #7 ice of cereal and salad			Operations Team, Quality Assurance Team		
	9-3-4(a)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		15G422	B. WIN			06/07/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	8			SHERMAN AVE	
COMMU	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46220	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0249	formulated a clie each client must treatment progra interventions and	nterdisciplinary team has ent's individual program plan, receive a continuous active am consisting of needed d services in sufficient				
	number and frequency to support the achievement of the objectives identified in the individual program plan.					
	ilidividuai progra	пп рап.	$ _{W0}$	240	CORRECTION: As soon as th	e 07/07/2012
			W 0	249	interdisciplinary team has	0//0//2012
		ation, record review, and			formulated a client's individual	!
	interview, for 1 of 4 sample clients (client #3), the facility failed to implement client #3's behavior plan as written.				program plan, each client mus	
					receive a continuous active	
					treatment program consisting	of
	_				needed interventions and	
	Findings include	•			services in sufficient number a	ınd
	1 1114111.85 111414.44				frequency to support the	
	On 5/29/12 from	5:25pm until 7:15pm,			achievement of the objectives identified in the individual	
		rom 5:25am until			program plan. Specifically, dire	ect
					support staff have been retrain	
	-	tions and interview were			regarding proper implementati	
	*	group home. During			of Client #3's Behavior Suppor	
	•	large butcher knives			Plan. Additionally, the facility h	
		the kitchen. On 5/29/12			added additional direct suppor staff on evenings and weeken	
	from 6:50pm unt	til 7:15pm, the two large			to increase supervision and	uo
	butcher knives w	vere placed into the dish			assure adequate staff are in	
	wash utensil rack	k, the dishwasher door			place to implement behavior	
	was open/down,	and the utensil rack was			supports as needed.	
	extended outwar	d fully exposed. From			PREVENTION: Facility	
		5pm, client #3 was			professional staff will be expect	ted
	•	the facility staff and			to observe no less than two morning and two evening activ	/A
		dishes from the sink into			treatment sessions per week t	
	the rack, accessed the kitchen, and was alone in the kitchen four (4) times. On				assess direct support staff	-
					interaction with clients and to	
		` '			provide hands on coaching an	d
		25am until 8:20am, the			training toward proper	
	two large butche	r knives were observed in			implementation of Individual a	nd

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE S COMPL		
THIND I LIMIN	or connection	15G422		LDING		06/07/	
		100122	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/	
NAME OF F	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		sher with the utensil rack		TAG	Behavior Support Plans.		DATE
	•	posed. From 5:25am			Additionally members of the		
	^	ent #3 had unsupervised			Operations and Quality		
	· ·	ess to the two large			Assurance Teams will periodic	-	
	butcher knives in	_			monitor active treatment on ar ongoing basis to assure quality		
	butcher kinves in	THE UCHSIT TUCK.			service delivery.	,	
	On 5/29/12 at 6·1	20nm_client #3 ran into			RESPONSIBLE PARTIES:		
	On 5/29/12 at 6:20pm, client #3 ran into her bedroom in the front of the house near the front door from the kitchen and the bedroom door slammed. Just as the door slammed, it reopened and client #3 was				QDDPD, Home Manager,	10	
					Support Associates, Operation Team, Quality Assurance Teal		
					, , ,		
	out the front door into the front yard alone						
	and no facility staff followed her. The						
		parked in front of the					
	windows to the f						
		w from the living room					
	_	e front yard. Client #3					
	walked across the	e front yard to the swing					
	near the road in f	front of the group home					
	and sat down. C	lient #3 pulled out her					
	cigarettes and lig	thter and began to smoke.					
	At 6:30pm, the R	Residential Manager					
	(RM) came to the	e door. The RM stated					
	client #3 "goes o	ut there to smoke"					
	independently.	The RM stated "she only					
		om workshop." At					
	* '	walked outside and					
	_	t #3 who sat smoking on					
	_	40pm, the RM and client					
		e the group home. At					
	_	stated client #3's level of					
	-	"we just keep track of her					
	every so often."						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	I DINC	00	COMPL	ETED
		15G422	A. BUI B. WIN	LDING		06/07/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹					
COMMU	NITY ALTERNATIV	ES ADEDT			SHERMAN AVE APOLIS, IN 46220		
COMMO	NIII ALIERIVATIV	ES-ADEF I		INDIAN	AFOLIS, IN 40220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	* '	the facility's investigations					
		indicated the following for					
		s of AWOL and Suicidal					
	Threats.						
		report for an incident on					
	3/27/12 at 11:25am, indicated client #3 had gone AWOL (Absent Without Leave) from workshop						
	· ·						
	twice; client #3 left a third time running into traffic down [street #3] into moving traffic						
	threatening to commit suicide.						
	tin catering to come	mir saiciae.					
	Client #3's Interdisc	ciplinary Notes (IDT) were					
	reviewed on 5/31/12 at 12noon and indicated the following:						
	-A 4/26/12 IDT ind	icated incidents on 3/27/12 and					
	3/20/12 at 1:16pm.	The IDT note indicated on					
		client #3 became upset, agreed					
		the workshop, then client #3					
		hair," became upset, left					
		building. The IDT note					
		hop staff walked with client					
		d, and group home staff came					
	to the workshop to	pick ner up. y from the QMRP-D (Qualified)					
		Professional-Designee)					
		Supervisor "called 5/4/12					
	-	ty board (at workshop) felt that					
	_	client #3] didn't return to					
	-	lue to the severity of her					
		[client #3] puts staff and					
		workshop name] states it's too					
	much of a risk."						
	Client #3's recor	d was reviewed on					
		am. Client #3's record					
	indicated client #3 was admitted to the						
	_	2. Client #3's 3/13/12					
		rgeted behaviors of					
	verbal aggression	n, physical aggression,					
			1				I

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Event ID: 3RYA11

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
MIDILAN	15G422	A. BUILDING		06/07/2012
	100 122	B. WING	ADDRESS SITE STATE STATES	30/01/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE	
COMMU	NITY ALTERNATIVES-ADEPT		APOLIS, IN 46220	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	non compliance, "AWOL defined as This			
	occurs when [client #3] is very frustrated or upset about an issue or when things do			
	no go her way. [client #3] will leave the			
	premises unsupervised, Suicidal Threats			
	(which is) any time [client #3] starts			
	implicating that nobody cares about her			
	and that she has nothing to live for,			
	therefore she wants to kill herself." Client			
	#3's 3/13/12 BSP indicated for AWOL			
	and Suicidal Threats behaviors staff were			
	to "Keep [client #3] in your sight at all			
	times when she leaves the			
	home/property," offer activity, and			
	document AWOL incident and behaviors.			
	On 6/1/12 at 10:45am, an interview with			
	the Qualified Mental Retardation			
	Professional (QMRP) was completed.			
	The QMRP indicated client #3 had			
	suicidal threats and leaving the workshop			
	AWOL in 3/2012. The QMRP indicated			
	client #3 was to be within eye sight of			
	facility staff for supervision. The QMRP			
	stated the facility had "locked up all the			
	sharps which included knives." The			
	QMRP stated client #3 "is not safe with			
	knives unless supervised."			
	9-3-4(a)			

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SU	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED		
		15G422	B. WIN			06/07/2012		
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF F	PROVIDER OR SUPPLIER				SHERMAN AVE			
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIANAPOLIS, IN 46220				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0252	criteria specified	accomplishment of the in client individual program nust be documented in						
ı			W0	252	CORRECTION: Data relative t	-	07/07/2012	
	Based on observa	ation, record review, and			accomplishment of the criteria			
	interview, for 1 of	of 3 sample clients (client			specified in client individual program plan objectives must	he		
	#3) who had a Behavior Support Plan (BSP), the facility failed to ensure accurate behavior data was recorded for client #3.				documented in measurable			
					terms. Specifically, direct supp	ort		
					staff have been retrained			
					regarding facility expectations	for		
	Findings include	:			documentation of behavioral episodes including but not limited to Client #3. PREVENTION: Professional staff will be retrained			
	On 5/29/12 at 6:2	20pm, client #3 ran into			regarding the need to monitor behavior documentation each			
	her bedroom in t	he front of the house near			time they are present in the ho	ome		
	the front door fro	om the kitchen and the			in order to provide guidance a			
	bedroom door sla	ammed. Just as the door			corrective measures to direct			
	slammed, it reop	ened and client #3 was			support staff in a timely manne	er		
	out the front doo	r into the front yard alone			to assure appropriate documentation of behavioral			
		aff followed her. The			situations occurs. Additionally,			
	· ·	parked in front of the			members of the Quality			
	windows to the f				Assurance and Operations			
		•				re		
	_	_				sure		
		•			behavioral episodes are record			
					and tracked to provide the tea			
		•				ort		
	-	_						
		•			Quality Assurance Team			
	` ′							
	_							
	blocking the view windows into the walked across the near the road in fand sat down. Concigarettes and light At 6:30pm, the R (RM) came to the client #3 "goes of the windows into the client #3 "goes of the windows into the walked across the windows into the walked across	w from the living room e front yard. Client #3 e front yard to the swing front of the group home lient #3 pulled out her ther and began to smoke. Residential Manager e door. The RM stated ut there to smoke" The RM stated "she only			and tracked to provide the tea with needed assessment data RESPONSIBLE PARTIES: QDDPD, Home Manger, Supp Associates, Operations Team,	sure ded m		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G422	B. WIN	G		06/07/	2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			5843 N	SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		om workshop." At					
	1 1	walked outside and					
	•	t #3 who sat smoking in					
		40pm, the RM and client					
	#3 returned insid	le the group home. At					
	6:40pm, the RM	stated client #3's level of					
	supervision was	"we just keep track of her					
	every so often."						
	On 5/20/12 at 4n	um the facility's					
	On 5/29/12 at 4pm, the facility's investigations were reviewed and						
	investigations were reviewed and indicated the following for client #3's						
		_					
		OL and Suicidal Threats:					
		S report for an incident					
		:25am, indicated client #3					
	_	(Absent Without Leave)					
	•	wice and left a third time					
	_	into traffic down [street					
	#3] into moving	traffic threatening to					
	commit suicide.						
	Client #3's Interd	disciplinary Notes (IDT)					
		n 5/31/12 at 12noon and					
	indicated the following						
		indicated incidents on					
		0/12 at 1:16pm. The IDT					
		13/20/12 at 1:16pm,					
		* *					
		e upset, agreed to sit in					
		vorkshop, then client #3					
	"jumped from her chair," became upset,						
	left AWOL outside the building. The IDT						
	note indicated the workshop staff walked						
	-	lient #3 calmed, and					
	group home staff	f came to the workshop to					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		15G422	B. WIN			06/07/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	NITY ALTERNATIV	ES ADEDT			SHERMAN AVE APOLIS, IN 46220		
	NITY ALTERNATIV				APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG		ROSS-REFERENCED TO THE APPROPRIATE	
IAG		behavior data was	+	IAG	,		DATE
		client #3's record.					
	documented on C	ment #3 s record.					
	Client #3's recor.	d was reviewed on					
	5/31/12 at 11:20am. Client #3's record indicated client #3 was admitted to the						
	facility on 2/2012. Client #3's 3/13/12						
	BSP indicated targeted behaviors of "AWOL defined as This occurs when						
	[client #3] is very frustrated or upset						
	about an issue or when things do no go						
	her way. [Client #3] will leave the						
	, ,	rvised, Suicidal Threats					
		me [client #3] starts					
	`	nobody cares about her					
		nothing to live for,					
		nts to kill herself." Client					
		P indicated for AWOL					
		eats behaviors staff were					
		#3] in your sight at all					
	times when she l	3 3 6					
		offer activity, and					
		L incident and behaviors.					
		d did not indicate					
	behavioral data.	a did not marcate					
	oona norar aata.						
	On 6/1/12 at 10:4	45am, an interview with					
	the Qualified Me						
	`	MRP) was completed.					
	` -	cated client #3 had					
	*						
	suicidal threats and leaving the workshop AWOL in 3/2012. The QMRP indicated						
		was documented and no					
	data was availab						
	aata mas a rando						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 06/0	e survey pleted 17/2012
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C SHERMAN AVE	ODE	
COMMUN	NITY ALTERNATIV	ES-ADEPT		APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	9-3-4(a)	LSC IDENTIFYING INFORMATION)	TAG	DEPICIENCY	THE THE PARTY OF T	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		15G422	A. BUII B. WIN			06/07/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUN	NITY ALTERNATIV	ES-ADEPT			APOLIS, IN 46220		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0264	483.440(f)(3)(iii) PROGRAM MON The committee s make suggestion practices and pro usage, physical r application of pai control of inappro of client rights an that the committee addressed. Based on observation interview, for 7 of #2, #3, #4, #5, #6 the group home, approval from the Committee (HRO employed. Findings include On 5/29/12 at 4p (Bureau of Devel Services) reports indicated the foll behaviors: -A 3/31/12 BDD on 3/25/12 at 9an went to the kitch threatened to hur handed the knife indicated a correct facility's HRC (Home) Committee) approvers	NITORING & CHANGE hould review, monitor and is to the facility about its orgams as they relate to drug restraints, time-out rooms, inful or noxious stimuli, orginate behavior, protection and funds, and any other areas see believes need to be ation, record review, and of 7 clients (clients #1, 6, and #7) who lived in the facility failed obtain e facility's Human Rights C) for restrictive practices : m, the facility's BDDS lopmental Disability were reviewed and owing for client #3's S report for an incident m, indicated client #3 en, "grabbed" a knife, t herself, and later to staff. The report ctive action of the Iuman Rights oved a verbal emergency	Wo		CORRECTION: The committee should review, monitor and masuggestions to the facility about its practices and programs as they relate to drug usage, physic restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee belieneed to be addressed. Specifically for Clients#1 – #7, team has obtained Human Rig Committee approval for securi knives and other sharp objects PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent and Human Rights Committee approval for restrictive programs prior to implementation. (Addendum, 6/29/12: retraining will focus or assuring that the QDDPD has clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications to the	ake ut sical us er ves the phts ng a a	07/07/2012
	Committee) appr	_			preparation for presenting		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G422	B. WIN	G		06/07/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOLVEIEN				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ated the staff "reminded			training will also focus on helpi	ng	
	[client #3] that when she acted in a				professional staff develop adequate record keeping		
	similar manner in	n the past that the police			practices to assure that HRC		
	came when she c	could not calm down and			approval records are available	for	
	was a risk to hers	self."			review.) Additionally, the agen		
					has established a separate		
	Client #3's record	d was reviewed on			Quality Assurance Department assist with auditing facility	to l	
		am. Client #3's record			systems. Members of the Qual	itv	
		\$\frac{1}{3}\$ was admitted to the			Assurance and Operations	,	
		2. Client #3's 3/13/12			Teams will periodically review		
		rgeted behaviors of			support documents and Huma		
		n, physical aggression,			Rights Committee Records on	an	
					ongoing basis to assure prior written informed consent and		
		"AWOL defined as This			HRC approval occurs for all		
	_	ent #3] is very frustrated			restrictive programs. (Addend	um	
	•	issue or when things do			6/28/12: The agency has		
	"	client #3] will leave the			established a quarterly system	of	
	1 ^	rvised, Suicidal Threats			internal audits that review all		
	l `	me [client #3] starts			facility systems including, but r limited to due process and price		
	implicating that	nobody cares about her			written informed consent.	"	
	and that she has	nothing to live for,			Administrative staff will conduct	t	
	therefore she was	nts to kill herself." Client			visits to the facility as needed I	out	
	#3's 3/13/12 BSF	indicated for AWOL			no less than monthly.		
	and Suicidal Thr	eats behaviors staff were			RESPONSIBLE PARTIES:	ort	
	to "Keep [client:	#3] in your sight at all			QDDPD, Home Manger, Suppl Associates, Operations Team,	UIT	
	times when she l	2 2			Quality Assurance Team		
		offer activity, and					
	1 1 1	L incident and behaviors.					
		did not include the HRC					
	_	arps and no written					
		rovals were available for					
	review.	TOVALS WELL AVAILABLE TO					
	ieview.						
	On 6/1/10 -4 10	15 om on intermiere (11)					
		45am, an interview with					
	the Qualified Me	ental Ketardation					

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	OF CORRECTION IDENTIFICATION NUMBER: 15G422	A. BUILDING B. WING	COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 5843 N SHERMAN AVE INDIANAPOLIS, IN 46220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	Professional (QMRP) was completed. The QMRP stated the facility was to have "locked up all the sharps which included knives." The QMRP stated client #3 "is not safe with knives unless supervised." The QMRP indicated HRC gave verbal consent for locked sharps on 3/30/12 and stated "No written approvals" were available for review. The QMRP indicated clients #1, #2, #4, #5, #6, and #7 did not have an identified need for the locked sharps, however to keep client #3 safe the sharps should be locked up. 9-3-4(a)		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	
		15G422	B. WIN			06/07/2	2012
	PROVIDER OR SUPPLIER			5843 N	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE JAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	The Children of the Control of the C		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0436	repair, and teach informed choices eyeglasses, hear communications	furnish, maintain in good n clients to use and to make s about the use of dentures, ring and other aids, braces, and other d by the interdisciplinary team					
			W0	436	CORRECTION: The facility mu	I	07/07/2012
	Based on observa	ation, interview, and			furnish, maintain in good repair		
	record review, fo	or 3 of 4 sample clients			and teach clients to use and to make informed choices about		
	(clients #1, #2, a	nd #3) and 1 additional			use of dentures, eyeglasses,		
	client (client #6)	who had adaptive			hearing and other		
	` ´	ribed, the facility failed to			communications aids, braces, and other devices identified by	,	
		rage client #1 to wear his			the interdisciplinary team as		
		lasses, client #2 to wear			needed by the client. Specifical direct support staff will be	ally,	
		nd prescribed eye			retrained regarding the need to		
	•	to wear her prescribed			implement Client #1,Client #2 : Client #3's adaptive equipmen		
	eye glasses, and	failed to provide client			goals as needed, at every	`	
	#6's walker repai	r.			reasonable opportunity. Additionally the facility will		
	Findings include				expedite repairs of Client #6's walker. PREVENTION: Facil professional staff will be expedite observe no less than two	,	
	1. On 5/29/12 fr	om 5:25pm until 7:15pm,			morning and two evening activ		
	and on 5/30/12 fi	rom 5:25am until			treatment sessions per week to assess direct support staff	0	
	8:20am, client #1	l walked throughout the			interaction with clients and to		
	group home, had	medication			provide hands on coaching and	d	
	administered, and	d did not wear his			training toward proper implementation of learning		
		lasses. On 5/29/12 at			objectives including but not		
		idential Manager (RM)			limited to adaptive equipment goals. Additionally, members of	,	
	• .	#1 to wear his eye glasses			the Operations and Quality Assurance Teams will conduct		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE S COMPL		
		15G422	A. BUII B. WIN	LDING		06/07/	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	and client #1 stat	ted "I lost them." Client			periodic active treatment		
	#1 was prompted	l to watch television, read			observations on an ongoing batto assure that clients are utilizing		
	a book, set the table, and rinse dishes				adaptive equipment as	''9	
	without his presc	ribed eye glasses			recommended. RESPONSIBLE PARTIES:		
	encouraged or fo	und.			QDDPD, Home Manger, Supp	ort	
					Associates, Operations Team, Quality Assurance Team		
	Client #1's record	d was reviewed on			Quality Assurance Team		
	5/31/12 at 11am.	Client #1's 3/22/12 ISP					
	(Individual Support Plan) indicated a						
	goal/objective "will make informed						
	choices about adaptive						
	equipment/eyegl	asses." Client #1's 8/8/11					
	vision evaluation	indicated client #1 wore					
	prescribed eye gl	asses.					
	2. On 5/29/12 fr	om 5:25pm until 7:15pm,					
	and on 5/30/12 fi	rom 5:25am until					
	8:20am, client #2	2 walked throughout the					
	group home, had	medication					
		d did not wear her					
	hearing aid and d						
	-	lasses. During both					
	observation perio						
		ch television, read a					
		le, and rinse dishes					
	1	cribed eye glasses and her					
	hearing aid.						
	Client #2's record	d was reviewed on					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G422	A. BUI B. WIN	LDING IG		06/07/	2012
NAME OF I	PROVIDER OR SUPPLIER	,	р. т		ADDRESS, CITY, STATE, ZIP CODE		
					SHERMAN AVE		
	NITY ALTERNATIV			<u> </u>	APOLIS, IN 46220		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	5/31/12 at 1:50pt	m. Client #2's 10/2/11					
	ISP did not indic	eate a goal/objective to					
	wear her prescrib	ped hearing aid and did					
	not indicate a go	al/objective to wear her					
	prescribed eye g	lasses. Client #2's					
	10/26/11 hearing	g evaluation indicated she					
	wore a hearing a	id because of bilateral					
	hearing loss. Cli	ient #2's 7/7/11 vision					
	evaluation indica	ated she wore prescribed					
	eye glasses.						
		om 5:25pm until 7:15pm,					
	and on 5/30/12 f	rom 5:25am until					
	•	3 walked throughout the					
	group home, had						
	administered, and	d did not wear her					
	1 -	lasses. During both					
	_	ods client #3 was					
		ch television, read a					
	book, take a wall	k outside, smoke outside,					
	read the newspap	per, and rinse dishes					
	without her preso	cribed eye glasses.					
	G1:						
		d was reviewed on					
		am. Client #3's 4/22/12					
		goal/objective to clean her					
	-	lasses. Client #3's 4/6/11					
		n indicated she wore					
	prescribed eye gi	lasses.					

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	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) N N OF CORRECTION IDENTIFICATION NUMBER:			NO NUMBER OF THE PROPERTY OF T			ETED
		15G422	A. BUI B. WIN	LDING		06/07/	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R.			SHERMAN AVE		
COMMUI	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1710	REGULTION OR	LEGE IDENTIFIEND IN ORWITTON)		mo	<u> </u>		DATE
	4 On 5/29/12 fr	om 5:25pm until 7:15pm,					
		rom 5:25am until					
		6 walked throughout the					
		did not use his walker for					
	` `	0/12 at 6am, client #6					
	stated his walker						
		t #6 showed his walker					
	with worn wheels. Client #6 indicated his						
	walker wheels with the padding grips						
	were missing and exposed the metal						
	_	ker to contact with the					
		stated "I was to get a new					
	one. Don't have i	_					
	one. Bon t have i	it you.					
	Client #6's record	d was reviewed on					
		pm. Client #6's 7/15/11					
	·	eate a goal/objective to					
		Client #6's 11/5/09					
		assessment indicated he					
		Client #6's 5/2012					
	"Adaptive Equip						
		nance" record indicated					
		ce clean, rubber stops in					
		initialed off by the group					
	1 -	times a day for thirty-one					
	days in May, 201	-					
	, ~ 1. 1 , 2 0						
	On 6/1/12 at 10:4	45am, an interview with					
		· · · · · · · · · · · · · · · · · ·					
	<u> </u>						ı

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G422		LDING	NSTRUCTION 00	(X3) DATE COMPL 06/07/	ETED
NAME OF F	PROVIDER OR SUPPLIER		D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	NITY ALTERNATIV				SHERMAN AVE APOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	, (i =	DATE
	, , ,	lified Mental Retardation					
	**	e QMRP-D (Qualified					
	Mental Retardation						
		signee), and the Director					
		ance (DQA) was					
	-	three professional staff					
		‡1 wore prescribed eye					
	_	ld have worn his eye					
	_	ee professional staff					
		‡2 wore prescribed eye					
		earing aid, and should					
		and encouraged to use					
		ipment. The three					
	1	f indicated client #3 wore					
		lasses and should have					
	, ,	sses. The QMRP					
		#6's walker was worn and					
	*	rvice held on 5/31/12					
		that client #6's walker					
		n the data information					
	-	MRP indicated client					
	#6's walker was	in need of repair.					
	0.2.7()						
	9-3-7(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		15G422	B. WIN			06/07/2012	
			1		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46220		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION)N
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W0454	483.470(I)(1) INFECTION CO	NTROI					
		provide a sanitary					
		ivoid sources and					
	transmission of i						
			W0	454	CORRECTION: The facility mu	ıst 07/07/201	12
	Raced on observ	ation and interview, for 7			provide a sanitary environmen	•	
		ents (clients #1, #2, #3,			avoid sources and transmission	n	
	•				of infections. Specifically, the		
		7) who lived in the group			facility has replaced its sharps		
	· ·	y failed to ensure a clean			disposal container with a new container that is less likely to be	10	
	area for medicati	on administration.			contaminated with blood or bo	•	
					fluids. Additionally staff have b	*	
	Findings include	:			retrained regarding bloodborne		
					pathogens and cleaning of		
	On 5/30/12 at 6:3	32am, client #5 entered			contaminated materials and th	е	
	the medication a	dministration room with			need to maintain universal precautions. PREVENTION :		
	Group Home Sta	ff (GHS) #4 and tested			Facility professional staff will b	e	
	his blood sugar.	Client #5 dripped blood			expected to observe no less th	•	
	_	onto the medication			two morning and two evening		
	_	ounter and on the handle			active treatment sessions per		
		rps container. No			week to assess direct support		
		encouragement to clean			staff to provide hands on coaching and training toward		
	_	observed. At 6:36am,			proper implementation of		
	client #4 had his				universal precautions and		
		GHS #4; client #4 laid			maintaining a sanitary training		
	_	counter where the			environment. Additionally,		
					members of the Operations an Quality Assurance Teams will	a	
		rom client #5 was. At			conduct periodic active treatme	ent	
	6:50am, client #2				observations on an ongoing ba	•	
		ompleted with GHS #1			to assure that the team support	ts	
	•	ent #2 touched the same			universal precautions and a		
		od smears, handled her			sanitary training environment. RESPONSIBLE PARTIES:		
		her fingers, and no			QDDPD, Home Manger, Supp	ort	
	redirection was t	aught or encouraged. At			Associates, Operations Team,	•	
	7:10am, client #1	l entered the medication			Quality Assurance Team		
	room with GHS	#1; client #1 had his					

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	of Correction identification number: 15G422	A. BUILDING B. WING	COMPLETED 06/07/2012
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET ADDRESS, CITY, STA 5843 N SHERMAN AVE INDIANAPOLIS, IN 4622	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) (X5) COMPLETION DATE
	medications administered after client #5's blood smears were still on the counter, and no redirection was taught or encouraged. At 7:30am, GHS #1 was shown the blood smears on the medication administration counter and GHS #1 stated "I didn't see it." GHS #1 stated "I didn't clean it" between clients. At 7:30am, GHS #1 retrieved the sharps container and stated "yes, there was blood" around the handle and access point to place sharp needles into the jug. On 6/1/12 at 10:45am, an interview with the QMRP (Qualified Mental Retardation Professional) was completed. The QMRP indicated the facility followed core A/core B for medication administration which included to wipe and clean the medication administration area free of spills before medication administration was completed for each client. The QMRP indicated clients #1, #2, #3, #4, #5, #6, and #7 used the medication administration area. 9-3-7(a)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPLI	ETED
		15G422	A. BUII B. WIN			06/07/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				SHERMAN AVE		
COMMU	NITY ALTERNATIV	ES-ADEPT			IAPOLIS, IN 46220		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0460	Each client must well-balanced die specially-prescril Based on record	receive a nourishing, et including modified and bed diets. review, observation, and of 2 sampled clients	W0-	460	CORRECTION: Each client more receive a nourishing, well-balanced diet including		07/07/2012
		_			modified and specially-prescri		
		vas to receive a modified			diets. Specifically, staff have b	een	
		failed to ensure client #6			retrained on Client #6's dining plan, and his diet is being		
	received his pres	cribed diet.			prepared and served as		
	Findings include:				prescribed. PREVENTION: Professional staff will be retrai regarding the need to provide		
	On 5/29/12 at 6p	m, client #6 received one			ongoing supervision during me	eal	
	serving of a one	foot long by six inch			preparation and during family	_	
	wide slice of pizz	za. Client #6 cut the			style dining to assure foods ar prepared and served in an	e	
	pizza with a rock	ter knife into four pieces			appropriate texture. Additional	ly,	
	and consumed it.	No redirection was			members of the Operations ar		
	observed and no	double portions were			Quality Assurance Teams will		
	encouraged.	•			periodically observe active treatment sessions at the facili	it.,	
					on an ongoing basis, to assure	•	
	On 5/30/12 at 7:5	50am, client #6 received			food is prepared and served		
		Client #6 cut the toast in			prescribed diets.		
		ed it. No redirection was			RESPONSIBLE PARTIES:	,	
		double portions were			QDDPD, Home Manger, Supp Associates, Operations Team,		
	encouraged.	doddie portions were			Quality Assurance Team		
	cheouragea.						
	was reviewed and "Physician's Order at least 75% intal supplements, End						
	offer double port	tions of meat items,					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G422	A. BUILDING B. WING			COMPLETED 06/07/2012	
	ROVIDER OR SUPPLIER		<i>p.</i> wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE SHERMAN AVE APOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
TAG	Ensure Plus Supp daily, suggest sm foods and foods of pieces." On 6/1/12 at 10:4 completed with the Mental Retardation QMRP indicated had his food cut to and client #6 sho	blement give one can sall frequent meals, softer chopped into pea size 45am, an interview was the QMRP (Qualified on Professional). The client #6 should have up into pea size pieces uld have been offered double portions of food.		TAG	DEFICIENCY)	E	DATE

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIJII DING		00	COMPLETED	
		15G422	A. BUILDING B. WING			06/07/2012	
			B. WIN		A DDDDGG GUTY GTA TO GID GODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY ALTERNATIVES ARERT				5843 N SHERMAN AVE			
COMMUNITY ALTERNATIVES-ADEPT				INDIANAPOLIS, IN 46220			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)		DATE
W0488	DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her						
	developmental level.		W0488				0-10-10-1
					assure that each client eats in a		07/07/2012
	Based on observation, record review, and						
	interview, for 6 of 7 clients (clients #1,				manner consistent with his or her developmental level. Specifically, professional and direct support staff will be retrained regarding the need to include all clients in		
	#2, #4, #5, #6, and #7) who lived in the						
	group home, the facility failed to						
	encourage, teach, and include clients to						
	shop for food.			the grocery shopping		rocess.	
	shop for food.				PREVENTION: Facility		
	Findings include:			supervisors will provide oversig			
					to assure all clients receive the opportunity to participate in grocery shopping on an ongoing		
	On 5/29/12 from 5:25pm, until 7:15pm, and on						
	5/30/12 from 5:25am until 8:20am, clients #1, #2,						
	#3, #4, #5, #6, and #7 were observed at the grou				basis. Members of the Quality Assurance and Operations		
		observation and interview			Teams will periodically review		
_		\$2, #4, #5, #6, and #7 indicated			facility progress notes to confi		
-		ed the opportunity to shop for			that all clients are participating		
-		ts #1, #2, #4, #5, #6, and #7			grocery shopping and follow up		
_		store to shop. On 5/30/12 at			with facility professional staff a		
· · · · · · · · · · · · · · · · · · ·		dicated she was going to stay			needed. RESPONSIBLE		
		roup Home Staff) #1 and go			PARTIES: QDDPD, Home		
	grocery shopping with GHS #1. GHS #1				Manger, Support Associates,		
	indicated GHS #1 c	ompleted the grocery shopping			Operations Team, Quality Assurance Team Corrections completed by: 7/7/12		
	every week.						
	On 6/1/12 at 10:45am, an interview with the						
	QMRP (Qualified Mental Retardation						
	Professional) was completed. The QMRP						
	indicated clients #1, #2, #4, #5, #6, and #7 should have the choice of shopping for groceries. The						
		11 6 6					
		documented evidence was					
	available for review for grocery shopping outings.						
	9-3-8(a)						

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