

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: December 5, 6, and 7, 2011.</p> <p>Provider Number: 15G597 AIM Number: 100245600 Facility Number: 001111</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/QMRP-Team Leader Tim Shebel, Medical Surveyor III/QMRP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/14/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			
W0157	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement effective corrective actions for 5 of 5 reviewed medication administration errors which affected 4 of 8 clients living at the group home (clients #1, #3, #4, and #8).</p>	W0157	On 12/13/11 all facility staff were trained on an additional compliance check that is required during all medication passes. One staff will be assigned to the medication administration, and responsible for all compliance checks. Once the medication is ready to be administered staff B	12/13/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>The facility's incident reports from 12/5/10 to 12/5/11 were reviewed on 12/5/11 at 12:50pm.</p> <p>1. "Incident Date: 09/24/2011 at 7am, Client: [Client #1], Narrative: During a med. (medication) audit, it was discovered that [Client #1] did not get his complete dosage of Seroquel 400mg (milligrams) (mood stabilizer). [Client #1] should have received two pills but only received one." The report indicated "since missing the partial dose has shown no noticeable increase in mood instability." The report indicated "appropriate training and discipline will take place. Training will include a supervised medication pass."</p> <p>2. "Incident Date: 11/4/2011 at 5pm, Client: [Client #3], Narrative: While passing medications it was discovered that [client #3] did not receive his complete dosage of Depakote 125mg. (to equal 100mg) (for mood instability). [Client #3] should have received 8 pills but only got 6 (pills). Since missing this partial dosage [client #3] has not shown any increased mood instability." The report indicated "appropriate training and discipline will take place. Training will include a supervised medication pass."</p>		<p>will check the medications and MAR for compliance. Only after the staff B checks the medications, will they be given to the resident. If an error is made, both staff members will be disciplined according to policy. If there is an error with the two staff process, a template will be instituted. With the template there will be the two staff compliance, but staff will be required to place each pill on a template and match them to the MAR. Failure to pass medications without error will result in disciplinary action according to agency policy.</p> <p>PERSONS RESPONSIBLE: Nurse, Program Manager, Residential Manager, Facility Staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526
--	--

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. "Incident Date: 05/15/2011, Client: [Client #4], Narrative: During a med. pass on the morning of 5/16/11 it was discovered that [client #4] did not get his 6am dose of Aspirin (blood thinner) 81mg on 5/15/11. The report indicated "appropriate discipline and training will take place." The "Follow Up Description: Staff involved in error received discipline/training per ADEC medication error procedure before she administered medications again. Routine med. audits will continue to be completed and training on medication administration will be completed per Core A as a new staff member, annually, and on an individual basis as needed or per med error procedure."</p> <p>4. "Incident Date: 05/07/2011, Client: [Client #4], Narrative: During the noon medication pass on 5/8/11 it was discovered [client #4] was given Clonazepam (Clozaril Therapy) 50mg (for aggression) pill instead of Seroquel 200mg (for behavioral issues with saliva) he should have received." The report indicated client #4 did not experience any unusual behavioral incidents during the day on 5/7 or 5/8/11. The report indicated "appropriate training and discipline will take place." The 5/9/11 "Disciplinary Action Documentation" indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>following for DCS (Direct Care Staff) #6: "On 5/7/11 Clozapine 50mg was given in error, this 50mg dose was not to start until 5/8/11, [client #4] was still suppose (sic) to get a 25mg dose of Clozapine at 1pm on 5/7/11. [Client #4] was given both the 25mg and 50mg dose of Clozapine. Also Seroquel 200mg tablet was popped from med card, but not given on 5/7/11. Staff found this Seroquel (tablet) taped into the space where the 50mg Clozapine was suppose (sic)to be. So [client #4] did not receive his 1pm dose of Seroquel either." The report indicated the Staff person has received retraining on the specifics from Core A/Core B curriculum. Audits are ongoing and this person will be observed during med pass before passing meds alone. No recommendation from the physician."</p> <p>5. "Incident Date: 08/05/2011, Client: [Client #8], Narrative: During a med audit on 8/09/11, it was discovered that [client #8] did not receive his Flomax (for symptoms of enlarged prostatic hyperplasia BPH) at 7pm on 8/5/11." The report indicated client #8's "symptoms include difficulty urinating, painful urination, and urinary frequency and urgency. Staff do not report any increases of these symptoms." The report indicated "appropriate training and discipline will take place. Training will include a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0327	<p>supervised med pass." The report indicated "PCP (client #8's personal physician) was notified of missed medication. No new orders were given. There were no signs/symptoms of distress observed. The staff person involved in the error received retraining from nursing staff and the agency disciplinary policy was implemented."</p> <p>Nurse #1 was interviewed on 12/6/11 at 1:26pm. Nurse #1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." Nurse #1 further stated the "medication errors just continued even after the staff had been disciplined and retrained."</p> <p>9-3-2(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Based on record review and interview, the facility failed to document tuberculosis control testing in millimeter duration for 2 of 4 sampled clients (clients #3 and #4) who lived in the home.</p>	W0327	On 12/12/11 the Health Service Coordinator inserviced all staff that administer TB tests an inservice on appropriate documentation of findings .Staff were informed that they must document in "mm" not by writing "not significant." Nursing staff will	12/12/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Findings include:</p> <p>On 12/6/11 at 12:20pm, client #3's record was reviewed. Client #3's 5/27/2011 mantoux/tuberculosis control testing indicated the results were "not significant" and were not recorded or measured in millimeters. Client #3's 5/23/11 History and Physical signed by client #3's personal physician did not include testing for tuberculosis control.</p> <p>On 12/6/11 at 1:10pm, client #4's record review was reviewed. Client #4's 5/27/11 mantoux/tuberculosis control testing indicated results were "not significant" and were not recorded or measured in millimeters. Client #4's 3/8/11 History and Physical signed by client #4's personal physician did not include testing for tuberculosis control.</p> <p>On 12/6/11 at 1:55pm, an interview with the Residential Director of Operations (RDO) and LPN (Licensed Practical Nurse) #1 was completed. The RDO and LPN #1 both stated clients #3 and #4's tuberculosis control testing "should have been read in millimeters and was not." The agency's policy and procedure for tuberculosis control testing was requested for review.</p>		<p>review each TB test that is administered ensuring correct documentation and initialing the form. The individual who documented incorrectly no longer is employed at the agency. Failure to comply will result in disciplinary action. PERSON RESPONSIBLE: Nursing staff</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0368	<p>On 12/7/11 at 9:20am, an interview with the RDO was completed and the RDO indicated no further information was available for review. No policy/procedure for tuberculosis control testing was available for review.</p> <p>9-3-6(a)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to administer prescribed medications per physician's orders to 4 of 8 clients living at the group home (clients #1, #3, #4, and #8).</p> <p>Findings include:</p> <p>The facility's incident reports from 12/5/10 to 12/5/11 were reviewed on 12/5/11 at 12:50pm.</p> <p>1. "Incident Date: 09/24/2011 at 7am, Client: [Client #1], Narrative: During a med. (medication) audit, it was discovered that [Client #1] did not get his complete dosage of Seroquel 400mg (milligrams) (mood stabilizer). [Client #1] should have received two pills but only received one." The report indicated #1 "since missing the partial dose has shown no</p>	W0368	<p>On 12/13/11 all facility staff were trained on an additional compliance check that is required during all medication passes. One staff will be assigned to the medication administration, and responsible for all compliance checks. Once the medication is ready to be administered staff B will check the medications and MAR for compliance. Only after the staff B checks the medications, will they be given to the resident. If an error is made, both staff members will be disciplined according to policy. If there is an error with the two staff process, a template will be instituted. With the template there will be the two staff compliance, but staff will be required to place each pill on a template and match them to the MAR. Failure to pass medications without error will result in disciplinary action according to agency policy.</p> <p>PERSONS</p>	12/13/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>noticeable increase in mood instability."</p> <p>2. "Incident Date: 11/4/2011 at 5pm, Client: [Client #3], Narrative: While passing medications it was discovered that [client #3] did not receive his complete dosage of Depakote 125mg. (to equal 1000mg) (for mood instability). [Client #3] should have received 8 pills but only got 6 (pills). Since missing this partial dosage [client #3] has not shown any increased mood instability."</p> <p>3. "Incident Date: 05/15/2011, Client: [Client #4], Narrative: During a med. pass on the morning of 5/16/11 it was discovered that [client #4] did not get his 6am dose of Aspirin (blood thinner) 81mg on 5/15/11. The "Follow Up Description: Staff involved in error received discipline/training per ADEC medication error procedure before she administered medications again. Routine med. audits will continue to be completed and training on medication administration will be completed per Core A as a new staff member, annually, and on an individual basis as needed or per med error procedure."</p> <p>4. "Incident Date: 05/07/2011, Client: [Client #4], Narrative: During the noon medication pass on 5/8/11 it was discovered [client #4] was given</p>		RESPONSIBLE:Nurse, Program Manager, Residential Manager, Facility Staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G597		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/07/2011	
NAME OF PROVIDER OR SUPPLIER  ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Clonazepam (Clozaril Therapy) 50mg (for aggression) pill instead of Seroquel 200mg (for behavioral issues with saliva) he should have received." The report indicated client #4 did not experience any unusual behavioral incidents during the day on 5/7 or 5/8/11. The report indicated "appropriate training and discipline will take place." The 5/9/11 "Disciplinary Action Documentation" indicated the following for DCS (Direct Care Staff) #6: "On 5/7/11 Clozapine 50mg was given in error, this 50mg dose was not to start until 5/8/11, [client #4] was still suppose (sic) to get a 25mg dose of Clozapine at 1pm on 5/7/11. [Client #4] was given both the 25mg and 50mg dose of Clozapine. Also Seroquel 200mg tablet was popped from med card, but not given on 5/7/11. Staff found this Seroquel (tablet) taped into the space where the 50mg Clozapine was suppose (sic)to be. So [client #4] did not receive his 1pm dose of Seroquel either." The report indicated the Staff person has received retraining on to the specifics from Core A/Core B curriculum. Audits are ongoing and this person will be observed during med pass before passing meds alone. No recommendation from the physician."</p> <p>5. "Incident Date: 08/05/2011, Client: [Client #8], Narrative: During a med audit on 8/09/11, it was discovered that</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>[client #8] did not receive his Flomax (for symptoms of enlarged prostatic hyperplasia BPH) at 7pm on 8/5/11." The report indicated client #8's "symptoms include difficulty urinating, painful urination, and urinary frequency and urgency. Staff do not report any increases of these symptoms." The report indicated "PCP (client #8's personal physician) was notified of missed medication. No new orders were given. There were no signs/symptoms of distress observed. The staff person involved in the error received retraining from nursing staff and the agency disciplinary policy was implemented."</p> <p>Nurse #1 was interviewed on 12/6/11 at 1:26pm. Nurse #1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." Nurse #1 further stated the "medication errors just continued even after the staff had been disciplined and retrained."</p> <p>Client #1's 11/2011 physician orders were reviewed on 12/7/11 at 8:55am. Client #1's "Physician's Order" indicated "Seroquel 400mg tablet (mood stabilizer), give 2 tablets 800mg orally 2 times a day."</p> <p>Client #3's 11/2011 physician orders were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reviewed on 12/6/11 at 12:20pm. Client #3's "Physician's Order" indicated "Divalproex Sod for Depakote ER 125mg am (in the morning) (750mg), give 6 capsules orally every morning (and) Divalproex for Depakote ER 1000mg pm, give 8 capsules every evening (1000mg)."</p> <p>Client #4's 11/2011 physician orders were reviewed on 12/6/11 at 1:15pm. Client #4's "Physician's Order" indicated "Aspirin 81mg tablet chew (blood thinner), give 1 tab (tablet) daily, Clonazepam 1mg tablet (for Klonopin) (for behavior of compulsive acts), give 1 tablet orally times a day, Clozapine 200mg tablet, give 1 tab orally at bedtime (for behavior of aggression), Clozapine 50mg, give 1 tablet orally every morning and at 1pm daily (for aggressive behaviors), Divalproex Sod ER for Depakote 500mg (for behavior of swearing), give 2 tablets (1000mg) orally 2 times a day (for bipolar), Seroquel 200mg tablet, give 1 tablet orally daily at 1pm, 6pm (for behaviors of issues with saliva)."</p> <p>Client #8's 11/2011 physician orders were reviewed on 12/5/11 at 1:30pm. Client #8's 11/2011 "Physician's Order" indicated "Flomax (for symptoms of enlarged prostatic hyperplasia BPH)" one time daily.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0369	<p>Nurse #1 was interviewed on 12/6/11 at 1:26 P.M.. Nurse #1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." Nurse #1 further stated the "medication errors just continued even after the staff had been disciplined and retrained."</p> <p>9-3-6(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, the facility failed to assure medications were administered and labeled according to physician's orders for 2 of 4 sampled clients (clients #2 and #4.)</p> <p>Findings include:</p> <p>1. Client #2 was observed during the evening observation period on 12/5/11 from 3:40 P.M. until 5:40 P.M.. At 4:41 P.M., direct care staff #1 administered a tablet of Metformin (diabetic medication) to client #2. Client #2 was not observed to begin eating his evening meal until 5:37 P.M..</p>	W0369	<p>On 12/13/11 staff were trained on following medication orders and labels. Staff were retrained on administering medications with food or water as ordered. Staff were notified that if the medication label does not match the MAR to notify the pharmacy and nurse immediately. A medication audit will be conducted two times per week to ensure compliance in this area. all facility staff were trained on an additional compliance check that is required during all medication passes. One staff will be assigned to the medication administration, and responsible for all compliance checks. Once the medication is ready to be administered staff B will check the medications and MAR for compliance. Only after the staff B</p>	12/13/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 12/6/11 at 6:45am, client #2 was observed to receive his morning medication administration from Direct Care Staff (DCS) #7. DCS #7 administered client #2's "Metformin 1,000mg (milligrams)," client #2 took the medication, and no food was provided. At 7:17am, client #2 stated to DCS #8 "I want to eat, I'm feeling weak." DCS #8 asked client #2 to wait until medication administration for all clients was complete before eating. At 7:37am, client #2 consumed his first bite of breakfast.</p> <p>Client #2's record was reviewed on 12/6/11 at 1:05 P.M.. Review of client #2's 11/11/11 physician's orders indicated the following: "Metformin, give 1 tablet 2 times a day with morning and evening meals."</p> <p>Nurse #1 was interviewed on 12/6/11 at 1:26 P.M.. Nurse #1 stated client #2's Metformin should be administered "with a meal."</p> <p>9-3-6(a)</p>		<p>checks the medications, will they be given to the resident. If an error is made, both staff members will be disciplined according to policy. If there is an error with the two staff process, a template will be instituted. With the template there will be the two staff compliance, but staff will be required to place each pill on a template and match them to the MAR. Failure to pass medications without error will result in disciplinary action according to agency policy. PERSON RESPONSIBLE: Agency Nurse, QDDP, Res Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0436	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 client (client #4) who used a wheelchair, the facility failed to ensure client #4's wheelchair was in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/6/11 from 5:50am until 8:25am. During the observation period client #4 used a wheelchair for mobility. From 5:50am until 8:25am, the wheelchair's right arm rest had the metal exposed on the end, the stuffing hanging out, and torn vinyl. Client #4's wheelchair seat area had the support straps exposed with torn vinyl covering. Client #4 leaned to the left side of his wheelchair and shifted his body continuously within the seat area of the wheelchair.</p> <p>On 12/6/11 at 1:55pm, an interview with Nurse #1 was completed. Nurse #1 stated client #4 "had been recently" refitted for a wheelchair and "plans have been made" to repair client #4's wheelchair. Nurse #1</p>	W0436	<p>An assessment of needed wheelchair items for client #4 had been completed. All tiems including the seat and arm rests have been requested by the QDDP. We are waiting for the items from WheelchairHelp.Org, and they have provided client #4 with a loaner chair untill the items can be ordered and assembled on the chair. According to WheelchairHelp.Org the items will be available by approximately 1/22/11. In the future, when a wheelchair appears to be showing signs of wear and tear, an assessment of the needs will be completed promptly so that parts can be ordered.Failure to comply will result in disciplinary action.PERSONS RESPONSIBLE:QDDP, Res Manager</p>	12/22/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G597	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011
NAME OF PROVIDER OR SUPPLIER  ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 62836 PLANEVILLE AVE GOSHEN, IN46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>provided a 12/1/11 wheelchair assessment for client #4 and stated the "parts are being ordered." Nurse #1 indicated she did not know when client #4's wheelchair would be repaired.</p> <p>Client #4's record was reviewed on 12/6/11 at 1:10pm. Client #4's 12/1/11 Wheelchair assessment indicated he needed a wheelchair because he was unsteady to walk. Client #4's diagnosis included but was not limited to Cerebral Palsy. Client #4's 3/8/11 "Physical Exam" indicated "Concerns noted by the Physician: Some atrophy of legs. left knee swollen and tender." Client #4's 12/5/2010 "Healthcare Support Plan" indicated "Wheelchair used for locomotion (sic)."</p> <p>9-3-7(a)</p>				