

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G510	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 226 FOSTER AVE ELKHART, IN 46516
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(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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: July 7, 8, 9, 10, 11, and 14, 2014</p> <p>Facility Number: 001024 Provider Number: 15G510 AIM Number 100249450</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review completed 7/16/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <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, the facility failed to encourage and teach 1 of 2 sampled clients who</p>	W000436	On 7/18/14 all staff were trained on prompting client #2 to wear his glasses. At most times client will independently do so. A goal is in	07/18/2014

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.

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	<p>wore eyeglasses (client #2) to wear his prescribed eyeglasses.</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation periods on 7/8/14 from 3:17 P.M. until 5:30 P.M. and on 7/9/14 from 6:48 A.M. until 7:45 A.M. and during the day program observation period on 7/9/14 from 1:11 P.M. until 2:00 P.M. During all observation periods, client #2 did not wear his eyeglasses nor did direct care staff #1, #2, #3, #4, #5, and #6 prompt or assist client #2 to wear his eyeglasses.</p> <p>Client #2's record was reviewed on 7/10/14 at 9:22 A.M. A review of the client's 3/13/13 vision exam indicated client #2 was to be wearing eyeglasses.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 7/10/14 at 9:26 A.M. QIDP #1 stated, "Staff should be prompting him (Client #2) to wear them (eyeglasses)."</p> <p>9-3-7(a)</p>		<p>place addressing the need to use adaptive equipment. In order to prevent this deficient practice in the future, the QIDP and manager will complete adaptive equipment audits for all clients in the home three times per week. Person Responsible:QIDP</p>				

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

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