

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 19816-3 SR 120 BRISTOL, IN 46507
--	--

(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: March 3, 4, 5, 6, and 7, 2014.</p> <p>Facility number: 000589 Provider number: 15G017 AIM number: 100248520</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed March 17, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed to assure direct care staff prompted or assisted 1 of 4 sampled clients (client #2) and 1 of 4 additional clients (client #8) in wiping excessive saliva from their mouths and chin areas.</p> <p>Findings include:</p>	W000268	<p>Client #2 is being discharged from the facility on 3/20/14. Client #8 has a goal in place to wipe his chin when drooling. Staff are being trained on implementation of this goal. Staff will prompt him and any other person served who may be drooling to wipe their face. The res manager and QDDP will conduct observations</p>	03/21/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 19816-3 SR 120 BRISTOL, IN 46507		
(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>Clients #2 and #8 were observed at the group home during the 3/4/14 observation period from 2:53 P.M. until 5:20 P.M. During the observation period, client #2 had excessive saliva dripping from his mouth. The saliva continuously dripped off the client's chin onto the kerchief around his neck. Direct care staff #1 and #3 each prompted the client once to wipe his mouth, however, saliva continued to drip off of client #2's chin onto his chest area and onto the table where he sat. Also during the observation, client #8 had excessive saliva dripping from his mouth. Saliva continuously dripped from his chin onto the table where he was sitting. Direct care staff #1, #2, #3, and #4 did not assist or prompt client #8 to wipe his mouth and chin area.</p> <p>Program Director #1 was interviewed on 3/7/14 at 10:39 A.M. Program Director #1 stated, "[Client #2] does have excessive amounts of saliva and it does tend to drip continuously. [Client #8] also has excessive amounts of saliva and it tends to drip from his mouth. Direct care staff should have prompted or assisted [client #2 and client #8] in wiping their mouths and chin areas."</p> <p>9-3-5(a)</p>		at least three times per week to monitor progress in this area. Person Responsible: QIDP and Res Manager		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 19816-3 SR 120 BRISTOL, IN 46507
--	--

(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