

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G800	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/08/2016
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6803 LUTZ DR SOUTH BEND, IN 46614
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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
W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 4, 5, 6, 7, and 8, 2016.</p> <p>Facility number: 012598 Provider number: 15G800 AIM number: 201023280</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 4/08/16 by #09182.</p>	W 0000		
W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 1 of 4 additional clients (client #4), and 2 of 4 additional clients (clients #7 and #8) wore clean, well fitting clothing.</p> <p>Findings include:</p>	W 0137	STAFF HAVE BEEN INSERVICED ON THE IMPORTANCE OF WEARING CLEAN CLOTES THAT ARE WORNN CORRECTLY FACILITY STAFF DID TAKE CLIENT #4 TO HIS ROOM TO CHANGE HIS SHIRT BUT HE REFUSED THIS WRITER SOPENT TIME WITH CLIENT #7 NOT NOTICING HIS	04/22/2016

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>Clients #4 and #7 were observed during the group home observation period on 4/5/16 from 3:11 P.M. until 6:00 P.M. During the entire observation period, client #4 wore a shirt that was deeply stained. Client #7 was wearing pants that were on backwards. Direct care staff #1, #2, #3, and #4 did not assist or prompt client #4 in putting on a shirt without stains, and did not assist or prompt client #7 in changing his pants so the client was wearing them appropriately.</p> <p>Client #8 was observed during the group home observation period on 4/5/16 from 3:11 P.M. until 6:00 P.M., and during the group home observation period on 4/6/16 from 5:56 A.M. until 7:30 A.M. During both observation periods, client #8 was wearing the same plaid shirt and tan pants. Direct care staff #2, #3, #4, #6, and #7 did not prompt or assist client #8 to dress in clean clothing on 4/6/16.</p> <p>Director of Residential Services #1 was interviewed on 4/7/16 at 11:48 A.M.. Director of Residential Services #1 stated, "Staff (direct care staff) should have made sure [client #4] was wearing a clean, unstained shirt and they (direct care staff) should have noticed and assisted [client #7] in putting his pants on correctly. [Client #8] does sometimes try to wear the same clothes two days in a</p>		<p>SWEATS WERE ON BACKWARDS IT WAS NOT UNTIL HE TRIED TO PUT SOMETHING INTO HIS POCKET WHEN STAFF WOULD HAVE NOTICED STAFF WILL BE TRAINED ON LOOKING CLOSER TO SHORTS AND SWEATS THAT ARE MORE DIFFICULT TO NOTICE FRONT VS BACK THE MANAGER AND QIDP WILL MONITOR THIS DAILY, WITH FORMAL DOCUMENTATION THREE TIMES PER WEEK PERSON RESPONSIBLE: QIDP, RES MANAGERAddendum: All staff were trained on 4/22/16. When client #4 has soiled clothing, which is not often, staff continue to prompt him to change clothing when it becomes soiled. We monitor for all individuals to look nice and clean every day, and the manager will formally document her observations 3x week.</p>				

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W 0369 Bldg. 00	<p>row. Staff should have prompted him to change into clean clothes."</p> <p>9-3-2(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</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 2 of 11 administered medications were administered according to physician's orders for 1 of 4 sample clients (client #2).</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation period on 4/5/16 from 3:11 P.M. until 6:00 P.M. At 4:21 P.M., direct care staff #4 administered a 250 mg (milligram) Divalproex Sod (sodium) ER (extended release) tablet (mood stabilizer medication), and a 500 mg Divalproex Sod ER tablet to client #2. After taking the Divalproex Sod ER tablets, client #3 did not eat supper until</p>			W 0369	<p>ALL FACILITY STAFF WILL BE TRAINED ON FOLLOWING PHYSICIAN ORDERS STAFF WILL BE SPECIFICALLY TRAINED ON MAKING SURE THAT MEDICATIONS STATED TO GIVE WITH MEALS WILL BE PASSED ACCORDINGLY THE HOUSE QIDP, NURSE AND RES MANAGER WILL CONDUCT MED AUDUTS 2X WEEK FOR THREE MONTHS TO MAKE SURE THIS DEFICIENT P[RRACTICE IS RESOLVED PERSON RESPONSIBLE QIDP, MANAGER, NURSE</p> <p>Addendum: The staff who made the error, and all facility staff were trained on medication administration for all clients including client#2. This training including giving medication with meals. Observing the medication pass twice a week will provide accurate insight as to</p>		04/22/2016

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	<p>5:42 P.M.</p> <p>Client #2's record was reviewed on 4/6/16 at 8:19 A.M. Review of client #2's 2/13/16 physician's orders indicated the following orders: "Divalproex Sod ER 250 mg tab (tablet). Take one tablet by mouth with one {500 mg tablet} daily at supper. Divalproex Sod ER 500 mg tab. Take one tablet by mouth with one {250 mg tablet} daily at supper."</p> <p>Nurse #1 was interviewed on 4/7/16 at 11:48 A.M. Nurse #1 stated, "The Divalproex should have been given with his (client #2's) supper."</p> <p>9-3-6(a)</p>				<p>if the correction has been made. On a daily basis, two staff are involved in all med passes, One individual, passes the meds, and the other monitors for compliance. there have been no concerns since this has been implemented. Med audits are completed by the med-flex three times per week in addition to the above stated.</p>		