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 05/01/2012

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

(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
W0000	This visit was a fundamental recertification and state licensure survey. Dates of Survey: April 23, 24, 25, 26, May 1, 2012. Facility number: 000589 Provider number: 15G017 AIM number: 100248520 Surveyor: Susan Reichert, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/9/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

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.

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W0247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation and interview, the facility failed for 1 additional client (client #5) to ensure he was offered choice in approved menu items. Findings include: Observations were completed at the group home on 4/23/12 from 4:55 PM until 7:18 PM. During the evening meal which consisted of a meat and pasta dish, peas, fruit cocktail, milk and water, client #5 attempted to serve himself a second portion of the pasta dish. Staff #13 took the pasta bowl from client #5 stating, "You know you are not allowed to have seconds," and "drink your milk." Client #5 was not offered an alternative menu item. Observations were completed at the group home on 4/24/12 from 6:33 AM until 7:58 AM. During breakfast client #5 served himself a second spoonful of oatmeal after he indicated he wanted more, and staff #1 moved the oatmeal dish away from client #5 after he set it down. There was not an alternative menu item offered to client #5.	W0247	On 5/3/12 all staff were trained on offering client #5 appropriate alternatives when he requests seconds of food items that are not good for his health. Staff were also instructed on how to approach client #5 when he asks for more food. On 5/4/12 a goal was put into place for client #5 to learn what foods are good for him so that he can maintain not taking medications for his diabetes.In order to make sure this correction is implemented, the QDDP will complete active treatment monitoring two times per week at meal time.Failure to comply will result in disciplinary actionPerson Responsible: QDDP	05/04/2012

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	The house manager was interviewed on 4/24/12 at 7:35 AM. She indicated client #5 had diabetes which was controlled by diet and indicated he was not to have second portions of carbohydrates, but could have additional vegetables. Client #5's record was reviewed on 4/24/12 at 2:30 PM. A nutritional assessment dated 2/21/12 indicated NCS (no concentrated sweets), regular diet and client #5's diabetes was controlled by diet. There were no recommendations regarding second portions or alternative menu items for client #5. The Director was interviewed on 4/24/12 at 3:45 PM and when asked about second portions for client #5 indicated following client #5's diet was not a choice as the facility was following orders for health. The Qualified Mental Retardation Professional (QMRP) and the Health Services Coordinator HSC were interviewed on 4/25/12 at 11:23 AM. The HSC indicated staff should have offered menu items that were available on his diet such as vegetables and client #5's diabetes was controlled by diet. 9-3-4(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based upon observation, interview and record review for 1 of 4 sampled clients (client #3) and 1 additional client (client #5), the facility failed to ensure individual support plan and behavior support plan objectives were implemented as written. Findings include: 1. Observations at the group home were completed on 4/23/12 from 4:55 PM until 7:18 PM. Client #5 indicated to staff he was upset about his broken watch. Client #5 continued to talk to staff about it and at 5:20 PM was asked by staff #12 to "stop obsessing" about his broken watch and wash his hands. The House Manager (HM) indicated to client #5 he would be taken to get a new watch tomorrow, and the HM stated "This is the best I can do-just put it in your pocket." Observations at the group home were completed on 4/24/12 from 6:33 AM until 7:58 AM. Client #5 sat on the sofa and	W0249	On 5/3/12 all facility staff were trained on implementing client #5's BSP and implementing the proactive measures as written. The QDDP and or the Manager will conduct active treatment monitoring two times per week making sure that the plan is being followed.Failure to comply will result in disciplinary action.Person Responsible: QDDP, Res Manager	05/03/2012

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	talked about his broken watch. The HM stated, "Why are you obsessing? You're getting a new one." Client #5's record was reviewed on 4/24/12 at 2:30 PM. A Behavior Support Plan (BSP) dated 5/20/11 indicated client #5 "needs cues to remind him how to behave appropriately...In the present program staff uses cues to redirect [client #5] when he is exhibiting appropriate behaviors. [Client #5] receives prompts and continues to be trained to leave a situation that troubles him; also to use his leisure skills to calm and gain control of himself." Client #5's target behaviors included bossing, verbal aggression, physical aggression, inappropriate interaction, signs of depression, elopement, self-deprecating statements, and stealing/sneaking food. "All staff members are to be positive in their expectations of [client #5] and through asking him to 'act as a gentleman,' to which his does respond well." If client #5 is "arguing with staff or peers...staff should redirect [client #5] to activities such as walking with them or listening to a cassette tape or watching a movie in his room." A revised goal for affective development dated 10/6/11 indicated client #5 "will learn how to respond to others in an agreeable manner." Methodology included asking client #5			

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	questions such as "what is the best way to reply when someone... Asks you to wait? OK. Disagrees with you? Don't get mad...Says something you don't like? I don't like that in a calm voice." A revised goal to increase affective skills dated 2/8/12 indicated client #5 was to engage in 1 to 1 discussion with staff upon return from day services. The Qualified Mental Retardation Professional was interviewed on 4/25/12 at 11:50 AM and indicated staff could have used the techniques in client #5's plan to address his expressed concerns about his broken watch. 2. Client #3 indicated to staff #3 during administration of medication at 6:15 PM on 4/23/12 he needed to use the restroom and he indicated he couldn't wait. Staff #3 asked him if he could wait until after he received his medications and he indicated he could wait. Client #3 received his medications at 6:30 PM in his bedroom. At 6:35 PM, client #5 indicated to the HM he needed to go to the restroom to have a BM (bowel movement). The HM indicated he needed to wait, but client #5 indicated he needed to use the restroom and couldn't wait. The HM indicated he required two staff to assist him to the toilet and client #3 stated, "I can't hold it." The HM got staff			

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	#7 to assist client #3 to the restroom and stated to client #3, "You're in luck," and "Sometimes there aren't enough hands." Client #3's records were reviewed on 4/24/12 at 12:30 PM and indicated a toileting goal dated 3/1/12 to urinate in the toilet, not on the floor. The methodology included assisting client #3 onto the toilet. A goal dated 3/1/12 indicated to request assistance when getting out of bed. Methodology included asking client #3, "When you need to get up what should you do? Answer: Call for help." A side rail assessment dated 7/28/10 indicated "transfers only with staff assistance." The Director was interviewed on 4/24/12 at 3:45 PM and indicated there were enough staff in the home to meet the needs of clients. The Qualified Mental Retardation Professional (QMRP) was interviewed on 4/25/12 at 11:23 AM and indicated client #3 shouldn't have had to wait as long as he did for assistance in toileting. 9-3-4(a)			

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W0264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical 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 believes need to be addressed. Based on observation, interview, and record review, for 1 of 4 sampled clients (client #4), the facility failed to ensure the facility's Human Rights Committee (HRC) reviewed and approved the use of sedation for a routine dental exam. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/23/12 at 3:10 PM and included a report dated 4/20/12 which indicated client #4 had been given general anesthesia for a dental cleaning. Client #4's record was reviewed on 4/24/12 at 1:04 PM and failed to include evidence of the facility's HRC review and approval of a plan that included the use of	W0264	The QDDP and facility staff have been trained on the requirement for HRC approval of using general anesthesia for routine dental cleaning. The QDDP will also implement a desensitization plan for any individual including client #4 who requires this intervention.The restrictions will be presented to HRC as needed. Failure to comply with this correction will result in disciplinary action.Person Responsible: QDDP	05/03/2012

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	general anesthesia for routine dental cleaning for client #4. The Qualified Mental Retardation Professional (QMRP) was interviewed on 4/25/12 at 11:23 AM and indicated the facility had not presented the use of sedation for client #4's dental cleaning to the HRC and there was not a plan at the present time to address the need for client #4 to have sedation for routine dental procedures. 9-3-4(a)			

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W0368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 additional client (client #5) to administer medications per physician's orders. Findings include: During medication administration for client #5 on 4/23/12 at 6:00 PM, a review of the medication administration record (MAR) for April, 2012 indicated client #5 did not receive Dextroamphetamine ER (extended release) 20 mg; 1 capsule every morning (attention deficit hyperactivity disorder) from 4/9/12 until 4/13/12 "due to being out of med (medication)." The Health Services Coordinator was interviewed on 4/25/12 at 11:23 AM and indicated client #5 did not receive his medication of Dextroampethetamine from 4/4/12 until 4/22/12 when it was approved by Medicaid. She indicated the facility had to get approval for the medication from Medicaid in order to pay for it. 9-3-6(a)	W0368	All staff, the QDDP and the nursing staff have been trained that when a medication is prescribed we must provide the medication regardless of Medicaid approval of specific dosing. In the future we will call the pharmacy to coordinate the filling of the prescribed dose even if it takes a combination of approved medications to make the prescribed dose. Failure to comply will result in disciplinary action.Person Responsible: QDDP, Nurse, Res Manager	05/03/2012

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W0460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based upon observation, record review, and interview for 2 of 4 sampled clients (clients #2 and #3), and one additional client (client #7), the facility failed to ensure their food and beverages were prepared to the consistency as specified in physician's orders. Findings include: 1. Observations were completed at the group home on 4/23/12 from 4:55 PM until 7:18 PM. During medication administration at 4:55 PM, client #7 was given water that was the consistency of thin liquid to take with his pills. When asked about the consistency of the water, staff #3 indicated it was nectar thick. During the evening meal, client #3 consumed a pasta with meat dish ground into a consistency with 1/8 inch lumps. Clients #2, #3 and #7 were provided with liquid that was the consistency of thin liquid. Client #7 was given liquid in which a thickening agent had been added, but was of thin liquid consistency. The directions on the label indicated to use 2-3 teaspoons for 4 ounces of water, stir and let stand for one minute.	W0460	On 5/3/12 Staff were trained on serving the appropriate diet for all individuals. This included food and drink consistency. Staff were trained on using the instructions on the Thick It can and that the instructions are for 4 oz of liquid. Staff must measure out all drinks in oz to make sure the correct amount of thick it is used. Staff were instructed to no longer used cooked or steel cut oats for a pureed diet as they do not meet the requirements. In order to avoid the same errors, the QDDP and residential manager will conduct meal observations two times per week to make sure the correct consistencies are served.Failure to comply will result in disciplinary action.Person responsible: QDDP, Res Manager	05/03/2012

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	The House Manager (HM) was interviewed on 4/23/12 at 5:30 PM and stated client #3 was to be given a pureed diet that was of "oatmeal" consistency. Staff #7 was interviewed on 4/23/12 at 5:35 PM and indicated he had added 3 tablespoons of a thickening agent to client #7's 10 ounce glass of liquid. He indicated client #3 and #7's liquid was ready to be consumed. The HM was interviewed on 4/23/12 at 5:40 PM and stated client #3 and #7's liquids looked "a little thin." Staff then added more thickener to client #3 and #7's beverages. Observations were completed at the group home on 4/25/12 from 6:33 AM until 7:58 AM. During breakfast, client #3 was given oatmeal unaltered to eat. Staff #1 was interviewed on 4/25/12 at 7:30 AM and indicated client #2 was to be given nectar thickened liquids. Client #2's record was reviewed on 4/24/12 at 12:35 PM. Client #2's Choking/Swallowing Management Plan dated 6/21/11 indicated he was to be given nectar thick liquids. Client #3's record was reviewed on			

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	4/24/12 at 12:30 PM. Client #3's Nutritional Assessment dated 3/20/12 indicated he was to be given a pureed diet with nectar thickened liquids. Client #7's record was reviewed on 4/24/12 at 1:15 PM. Client #7's Nutritional Assessment dated 1/17/12 indicated he was to receive nectar thickened liquids. The Health Services Coordinator was interviewed on 4/25/12 at 11:23 AM and indicated pureed diet included foods that were the consistency of oatmeal. The facility's guidelines for Diet Orders (undated) was reviewed on 4/25/12 at 1:20 PM. Pureed diet indicated food was to be pureed in a blender to the consistency of mashed potatoes/soft pudding...Avoid ...hot cereals." Nectar thickened liquids indicated "nectars, vegetable juices and handmade milk shakes made with thickeners. Thin liquids can be thickened with commercial thickeners." Guidelines for Consistency Modifications of Food and Liquids (undated) was reviewed on 4/25/12 at 1:20 PM and indicated "When a thickened liquid is prescribed, the food consistency served must be **as least as thick** as the prescribed liquid." A picture of pureed food consistency indicated food without			

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	lumps and of smooth consistency. The Director was interviewed on 5/1/12 at 12:15 PM and indicated a pureed diet included oatmeal based upon her research on the Internet including nationally recognized dietetic organizations sites. The reference manual Diet and Nutrition in Long Term Care dated 2011 was reviewed on 5/1/12 at 12:48 PM and indicated "cereals should be smooth and of one consistency (usually cooked cereals such as cream of wheat or rice, or farina)." Foods to limit included "coarse cooked cereal." 9-3-8(a)			

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(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
W9999	460 IAC 9-3-1 Governing body Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. This state rule was not met as evidenced by: Based on record review and interview, the facility failed for 3 of 3 incident/accident internal reports reviewed involving falls resulting in injury involving clients #4 and #6 to report them immediately to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law. Findings include: The facility accident/illness reports were reviewed on 4/23/12 at 4:10 PM, and included the following reports of falls resulting in injury: -A report dated 4/5/12 indicated client #6 tripped over his feet and fell in the bathroom causing abrasions to 2 fingers and side of knee. There was no evidence of a report to BDDS of the fall.	W9999	On 5/3/12 all staff have been trained to report all falls with injury to the QDDP, Res Manager or on call staff immediately. All QDDP's and nursing staff are aware or the requirement to report within 24 hours any fall with injury. All accidents/injuries will be reviewed by the director.Failure to comply will result in disciplinary actionPerson responsible: QDDP, Res Manager, nurse	05/03/2012

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 05/01/2012

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	-A report dated 2/29/12 indicated client #4 fell while trying to sit on the toilet and hit his head on the wall causing a 2 cm (centimeter) cut on the back of his head). There was no evidence of a report to BDDS of the fall. The Director was interviewed on 5/1/12 at 12:36 PM and indicated the falls were not reported to BDDS as the injuries noted on the incident reports were not considered to be significant injury. The statewide Policy: Incident Reporting and Management dated 3/1/11 was reviewed on 4/30/12 at 7:15 PM and indicated the following: "Incidents to be reported to BQIS (Bureau of Quality Improvement Services) include...A fall resulting in injury, regardless of the severity of the injury...Within 24 hours of initial discovery of a reportable incident, the reporting person shall forward a copy of the electronically submitted incident initial report to...the individual's BDDS service coordinator...." 9-3-1(b)			