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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G779 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/14/2012 |
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| NAME OF PROVIDER OR SUPPLIER ADEC INC | STREET ADDRESS, CITY, STATE, ZIP CODE 10125 HEATHER LAKES DR OSCEOLA, IN 46561 |
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| W0000 | <p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: June 12, 13, and 14, 2012.</p> <p>Facility Number: 012439 Provider Number: 15G779 AIMS Number: 201018350</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 21, 2012 by Dotty Walton, Medical Surveyor III.</p> | W0000 | | |

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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| W0149 | <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) who was to receive a modified diet, the facility neglected to implement client #3's dining protocol and neglected to prevent her from having the wrong prescribed diet.</p> <p>Findings include:</p> <p>On 6/12/12 at 3:20pm, the facility's BDDS (Bureau of Developmental Services) reports were reviewed and indicated the following for client #3: -A 4/23/12 BDDS report for an incident on 4/21/12 at 6:05pm, indicated client #3 was "taken to ER (Emergency Room) via (by) ambulance at approximately 6:05pm after consuming fruit that was not pureed per [client #3's] diet order and started coughing." -A 4/27/12 BDDS follow up report indicated "[Client #3's] diet order for pureed food will continue to be followed. [Client #3] was sitting at the dining room table, another client next to her had fruit in a cup. [Client #3] grabbed the cup of fruit and began to eat it. That's when [client #3] began coughing and 9-1-1 was</p> | W0149 | <p>All staff will be trained on the appropriate amount of supervision needed for each individual as well as the correct diet for everyone. Client #3 now has a feeding tube and no longer sits at the table during meals. Staff participate with her in an activitiy during dining. In order to prevent this in the future, the QDDP will conduct weekly meal momitoring making sure all individuals are supervised with the correct diet.Failure to comply will result in disciplinary action.Person Responsible: QDDP Res Manager</p> | 06/29/2012 | | | |

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| | <p>called. The staff that was sitting next to [client #3] had turned (their) head and that is when the incident happened. [The staff] will continue to follow diet orders and always assist [client #3] when she is eating so that [client #3] can not grab other clients' food."</p> <p>On 6/12/12 from 5:50pm until 7:10pm, client #3 sat at the dining room table with the House Manager (HM), Group Home Staff (GHS) #1, GHS #2, and GHS #3. During client #3's meal observation period GHS #1, GHS #2, GHS #3, and the HM alternated their seats at the dining room table to sit between client #3 and other clients at the table and to assist feeding client #3 who consumed her diet of pureed foods and pudding thickened drinks.</p> <p>On 6/13/12 at 12:10pm, client #3's record was reviewed and indicated a 4/15/12 "Physician's Order" for "Diet, Regular Pureed, Pudding Thick Liquids." Client #3's 2/22/11 "Residential Review" indicated client #3 was "observed [client #3] eating pudding with hand over hand assistance...[client #3] tends to overstuff [food into her mouth]...occasionally took food from others' plates and required supervision (during meals and while eating)." Client #3's 3/2/12 "Health Care Support Plan" indicated "Diet</p> | | | |

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| | <p>Regular/Pureed, Pudding thick liquids." Client #3's 3/2/12 "Choking/Swallowing Management Plan" indicated client #3's "Date of Last Swallowing Evaluation: April 21, 2011. [Client #3] is at risk of choking due to a diagnosis of: Dysphagia." Client #3's Choking/Swallowing plan indicated "Staff will monitor [client #3] for choking during snacks and meals at all times."</p> <p>On 6/1/12 at 10:45am, an interview was completed with the QDP (Qualified Developmental Professional) and Agency Nurse #1. The QDP and Agency Nurse #1 both indicated client #3 was to have pureed foods and pudding thick drinks. Both the QDP and Agency Nurse #1 indicated client #3 was at risk for choking. Agency Nurse #1 stated client #3 "required before 4/21/2011" for staff to sit between her and other clients because client #3 "reaches out and grabs food" from other clients. The QDP indicated the facility followed the BDDS policy and procedure for abuse, neglect, and/or mistreatment.</p> <p>On 6/12/12 at 2:30pm, a review was conducted of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional,</p> | | | | |

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| | <p>physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>9-3-2(a)</p> | | | | |

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| W0436 | <p>483.470(g)(2) SPACE AND EQUIPMENT 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 2 sample clients (client #4) who had prescribed eye glasses, the facility failed to teach and encourage client #4 to wear her prescribed eye glasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/12/12 from 5:05pm until 7:25pm, and on 6/13/12 from 5:20am until 7:20am. During both observation periods client #4 was observed not to be wearing her prescribed eye glasses. On 6/12/12 at 5:45pm, client #4 was administered her medications by GHS (Group Home Staff) #1 and client #4 was not prompted and encouraged to wear her prescribed eye glasses.</p> <p>Observation was conducted at the workshop on 6/13/12 from 9:45am until 11:05am, client #4 did not wear her prescribed eye glasses.</p> <p>Client #4's record was reviewed on 6/14/12 at 9:10am. Client #4's 3/1/12 vision assessment indicated client #4 had prescribed eye glasses and a recommendation "to wear as much as [client #4] will tolerate." Client #4's 3/21/12 ISP (Individual Support Plan) did not indicate a goal/objective to wear her prescribed eye glasses.</p> <p>On 6/14/12 at 11am, an interview was conducted</p> | W0436 | <p>A goal will be written and trained to be implemented by 6/29/12. In order to prevent this in the future, the QDDP will review all medical progress notes when they are completed and implement recommendations as noted. If there is a need for a formal goal, one will be written. Failure to comply will result in disciplinary action. Person Responsible: QDDP, Res Manager</p> | 06/29/2012 | | | |

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| | <p>with the QDP (Qualified Developmental Professional) and the House Manager (HM). The QDP indicated client #4 had prescribed eye glasses. The QDP indicated client #4 did not have a formal goal to teach client #4 to wear her eye glasses. The QDP stated client #4 was taught and encouraged "informally to wear (client #4's eye glasses) during medication administration."</p> <p>9-3-7(a)</p> | | | |