

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G103	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/01/2016
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 LONGWOOD CT GOSHEN, IN 46526
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 28, 29, 30, and April 1, 2016</p> <p>Facility number: 000641 Provider number: 15G103 AIMS number: 100234120</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/7/16.</p>	W 0000		
W 0149 Bldg. 00	<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. Based on observation, interview, and record review, the facility neglected to implement their abuse/neglect policy to protect 1 of 4 additional clients (client #6) from verbal abuse from 2 of 7 additional clients living at the group home (clients #2 and #8).</p> <p>Findings include:</p>	W 0149	<p>ALL FACILITY STAFF HAVE BEEN TRAINED ON APPROPRIATE REDIRECTION OF NEGATIVE BEHAVIORS INCLUDING RUDE COMMENTS OF THOSE WHO RESIDE IN THE HOME STAFF UNDERSTAND THE CONCEPT OF CLIENT TO CLIENT VERBAL ABUSE IN ORDER TO PREVENT THIS IN THE FUTURE, STAFF INTERACTIONS WILL BE</p>	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 #2, #6, and #8 were observed during the group home observation period on 3/28/16 from 3:21 P.M. until 6:00 P.M. At 5:10 P.M., client #6 came out of his bedroom and told direct care staff #1 he was hungry. Direct care staff #1 told client #6 the evening meal would be done in a few minutes. Client #2 yelled at client #6, "Quit whining and behave yourself !" Client #8 yelled at client #6, "Hey, [client #6], kiss my butt!" Direct care staff #1, who heard clients #2 and #8's remarks did not say anything to clients #2 and #8 about their verbalizations and did not redirect the clients' behavior. Client #6 put his head down and went back into his bedroom.</p> <p>Director of Residential Services #1 was interviewed on 3/30/16 at 10:42 A.M. Director of Residential Services #1 stated, "[Direct care staff #1] should have redirected those guys (clients #2 and #8) from saying those remarks. He (direct care staff #1) should have told them (clients #2 and #8) that that was not acceptable behavior."</p> <p>The facility's records were reviewed on 3/30/16 at 11:07 A.M.. A review of the facility's "Incident Reporting and Management Policy" (Abuse/Neglect policy), dated 12/21/11, defined, in part, the following: "c. emotional/verbal</p>		<p>MONITORED DAILY, AND FORMALLY DOCUMENTED THREE TIME PER WEEK BY THE RESIDENTIAL MANAGER PERSON RESPONSIBLE: QIDP, RES MANAGER</p>				

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W 0369 Bldg. 00	<p>abuse, including but not limited to communicating with words or actions in a person's presence with intent to: iii. cause the individual to experience emotional distress or humiliation."</p> <p>9-3-2(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 10 administered medications were administered according to physician's orders for 1 of 4 sample clients (client #3).</p> <p>Findings include:</p> <p>Client #3 was observed during the group home observation period on 3/28/16 from 3:21 P.M. until 6:00 P.M. At 4:28 P.M., direct care staff #2 administered a 600 mg (milligram) 400 unit Calcium with Vitamin D tablet (nutritional supplement) to client #3. After taking the Calcium with Vitamin D tablet, client #3 did not</p>	W 0369	<p>THE PRESCRIPTION STATED "GIVE WITH FOOD" WHEN THE PHARMACY TRANSCRIBED THE SCRIPT, THEY INCORRECTLY WROTE"TAKE WITH MEALS" THE PHARMACY WAS NOTIFIED AND THE CORRECTION WAS MADE THE FACILITY STAFF PASSED THE MEDICATIONS AS PRESCRIBED BY THE PHYSICIAN FACILITY NURSING STAFF WILL MONITOR FOR INCONSISTENCIES IN TRANSCRIPTION OF ORDERS PERSON RESPONSIBLE: NURSING</p>	04/21/2016

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W 0455 Bldg. 00	<p>eat a meal until 5:47 P.M.</p> <p>Client #3's record was reviewed on 3/30/16 at 9:22 A.M. Review of client #3's 12/14/15 physician's orders indicated the following order: "Calcium W/D (with Vitamin D) 600-400 (600 milligrams of calcium and 400 units of vitamin D) tablet. Take one tablet by mouth twice a day with meals for nutritional supplement."</p> <p>Nurse #1 was interviewed on 3/30/16 at 10:26 A.M. Nurse #1 stated, "According to his (client #3's) physician's orders his (client #3's) Calcium (Calcium W/D) should have been given with a meal."</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client #1) did not put ice that had fallen onto the floor into his glass of water.</p> <p>Findings include:</p>	W 0455	STAFF HAVE BEEN TRAINED IN PROPER HYGIENE, AND THAT WHEN A CLIENT DRIPS ICE OR ANY EDIBLE ON THE FLOOR IT NEEDS TO BE DISPOSED OF THE RES MANAGER WILL MONITOR FORMALLY 3X PER	04/22/2016

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	<p>Client #1 was observed during the group home observation period on 3/28/16 from 3:21 P.M. until 6:00 P.M. At 5:28 P.M., client #1 poured himself a glass of water and got ice from the freezer. Client #1 dropped the ice on the floor of the kitchen and picked it up and put it in his glass of water. Direct care staff #2 stated, "You (client #1) can't put that ice in your water. It fell on the floor." Client #1 proceeded to sit at the dining room table and sip at his water. Direct care staff #2 did not prompt or assist the client in getting a glass of water with ice that did not fall onto the floor.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 3/30/16 at 10:42 A.M.. QIDP #1 stated, "She (direct care staff #2) should have made sure he (client #1) dumped his water and got a new glass with ice that didn't fall on the floor."</p> <p>9-3-7(a)</p>		<p>WEEK MAKING SURE HYGENIC PRACTICES ARE BEING FOLLOWED PERSON RESPONSIBLE: QIDP, RES MANAGER</p>		