STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G384	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA LUTHERAN COMMUNITIES INC	1601 STURDY RD VALPARAISO, IN 46383

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W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 10/1, 2, 3, 4 and 11, 2013. Facility number: 000898 Provider number: 15G384 AIM number: 100235150 Surveyor: Amber Bloss, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/28/13 by W. Chris Greeney, QIDP	W000000		

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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W000222	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include cognitive development. Based on observation, record review and interview, the facility failed to assess 1 of 3 sampled clients (#1) for declining cognitive ability in regard to memory loss. Findings include: On 10/1/13 between 4:35 PM and 6:28 PM, group home observations were conducted. At 5:08 PM, Client #1 was sitting on the couch in the living room and appeared lethargic. At 5:40 PM, DSP (direct support professional) #1 prompted Client #1 to come to the table for dinner to which Client #1 did not respond. At 5:45 PM, Client #2, #3, #4, #5, #6 were seated at the dining room table waiting for Client #1. DSP #1 asked Client #1 to come to the dining room table for dinner. At 5:48 PM, Client #1 came to the dining room table. At 6:17 PM, after dinner, Client #1 participated in after dinner devotional discussion. Client #1 appeared to forget the question DSP #1 asked her and had to be asked several times before responding. On 10/3/13 at 10:54 AM, record review indicated Client #1's diagnoses included, but were not limited to, Down's Syndrome with moderate Intellectual Disabilities, impaired vision, incontinence, memory loss due to aging, TMJ (temporomandibular joint disorder) syndrome (symptoms of the chewing joints and muscles of the lower jaw), untreated sleep apnea, sinus bradycardia, and impulse control disorder. During record review, an outpatient psychiatric evaluation dated 12/12/12 indicated "Pt (Client	W000222	Client #1 was assessed using the Down Syndrome Dementia Questionnaire on 10-16-13. This will be repeated at least annually or more often if changes warrant. Client #1 was re-evaluated by the psychologist using the WAIS-IV on 10-14-13. (See attached evaluation). Client # 1 was seen by her neurologist on 10-17-13. (See attached letter). He continues to believe that her cognitive decline is due to sleep apnea but cannot rule out Alzheimer's. A Decline in Cognitive Skills/Demential Protocol was written and staff were trained on it on 10-18-13. (See attached protocol and sign in sheet). Staff were also trained on Dementia in Developmental Disabilitis: An Introduction for Direct Support Staff. (See sign in sheet).All individuals supported who have Down Syndrome will be assessed on the Down Syndrome Dementia Questionnaire for a performance baseline. This will be repeated annually or more often if indicated. This questionnaire will also be used for individuals who do not have Down Syndrome but are showing a change in their congnitive skill level. Any significant changes or concerns in this area will be followed up by a psychological evaluation and neurological	10/18/2013

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	#1) came in and sat as far away as possible. Staff reports no change in behaviors. She used to have passive behaviors in which she would refuse to do things and literally (drop) on the ground or floor and need to be carried in. That hasn't occurred lately. I noticed she had her glove on backwards. She looked tired but says she is sleeping at night...ongoing memory problems." The evaluation indicated Client #1 appeared "slightly overweight, sits with mouth open, looks tired, sits passively, only answers simple questions, I observed her making involuntary jaw movements, denies depression, no irritability, slow thinking...". The evaluation indicated Client #1 had been prescribed Aricept 5mg daily (most commonly prescribed to treat mild to moderate dementia of the Alzheimer's type) since 6/22/2009. A "Health Provider's Progress Note" dated 4/17/13 indicated Client #1 had her Aricept discontinued on the 4/17/13 appointment with her neurologist. Review of the "Annual Case Conference" summary contained within Client #1's ISP (Individual Support Plan) dated 9/10/13 indicated Client #1's "medication Risperdal was decreased from 1mg to .5 mg in December, 2012. As a result, [Client #1] went through a period of several months in which she exhibited challenging behaviors. Her medication was increased back to 1 mg in March of 2013. Behaviors began to decrease and then level off." The conference summary indicated Client #1's "neurologist had discontinued the medication Aricept." The summary indicated "the medication is not considered to be beneficial after being on it for an extended period of time." The summary indicated it was reported Client #1 "has not been doing as well since Aricept was discontinued."		evaluation. The QIDP for the home will be responsible for ensuring that the Down Syndrome Dementia Questionnaire is completed at least annually for all individuals with Down Syndrome and for any other person who is showing cognitive decline. The team will discuss any changes and put in place a plan to ensure that necessary protocols, medical evalautions are completed in a timely manner. The Risk Management team will review the plan and the QIDP/Manager will be responmsbile for ensuring that this is done.	

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	Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 6/4/13 for targeted behaviors of non-cooperation and verbal outbursts. The BSP indicated "currently it appears that most of (Client #1)'s target behaviors stem from a desire to escape or avoid tasks that have been assigned to her. A secondary antecedent for (Client #1)'s target behaviors, is boredom, which results from her inability to amuse herself with appropriate meaningful activities and increases her desire for attention...". Client #1's BSP indicated Client #1 "has been demonstrating signs that indicate she may be experiencing a decline in cognitive skills due to the aging process, such as memory loss, decrease in independent living skills, and increased difficulty processing auditory stimuli. Her family doctor prescribed Aricept, but the effects are limited and further deterioration is expected." On 10/3/13 at 1:15PM, interview with the QDDP Manager (Qualified Developmental Disabilities Professional) indicated Client #1 has shown some loss of "cognition and skills" in the last 15 years. The QDDP Manager indicated Client #1's family has always considered this "memory loss due to aging". The QDDP Manager indicated there hasn't been a clear diagnosis for Client #1 of dementia and no protocol for dementia had been developed for Client #1. The QDDP manager indicated Client #1 would benefit from being assessed to clarify whether Client #1's memory loss was due to aging or a diagnosis of dementia. On 10/11/13 at 12:25 PM, the facility RN indicated there has been some confusion whether Client #1 has memory loss due to dementia or her untreated sleep apnea. The RN indicated Client #1's diagnosis needed to be confirmed. 9-3-6(a)			

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W000369	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, interview and record review for 1 of 18 medications administered, the facility failed to administer all medications/treatments without error for Client #4. Findings include: During the 10/3/13 observation period between 6:05 AM and 7:30 AM, at the group home, Direct Support Professional (DSP) #2 administered Client #4's morning medications. DSP #2 did not administer Client #4's Ocusoft Lid Scrub (Blepharitis-swelling/inflammation of eyelids) treatment. Client #4's Medication Administration Record (MAR) was reviewed on 8/13/13 at 7:40 AM. Client #4's 8/13 MAR indicated Client #4 had a treatment to apply Ocusoft Lid Scrub to his eyelids twice a day. The 8/13 MAR indicated the 8/13/13 area spot for initials was blank. Client #4's record was reviewed on 8/16/13 at 9:35 AM. Client #4's 8/13 physician orders indicated Client #4 was to receive Ocusoft Lid Scrub twice a day to eyelids. Interview with DSP #2 on 8/13/13 at 7:40 AM indicated he did not do Client #4's Ocusoft treatment as ordered. Interview with Client #4 on 8/13/13 at 7:41 AM indicated the client did not get his Ocusoft treatment at the morning medication pass.	W000369	All staff were retrained on the proper procedure for administering medications ordered to be taken after a meal. The staff person who made the medication error will be observed during the next three shifts that she works to ensure that she is following the correct procedure in administering medications. If no problems are noted during this time, she will be observed weekly for the next month. If no problems are noted during that period of time, she will be observed monthly for three months. If no problems are noted during that time, she will then be observed during routine house observations completed by the Program Manager. Observations will be documented on the Post Medication Error Observation Form. The Post Medication Error Observation form has been modified to include more immediate observations after a medication pass. Any staff making a med error, will be retrained by the nurse and will not pass medications until the nurse has observed the initial pass. After the initial observation, the nurse or program manager will observe the person on the next two shifts to ensure that the	10/18/2013

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	9-3-6(a)		medications are being given as ordered and following the correct procedure for administering medications. If no problems are noted then the observations will be done weekly for one month and then monthly during the next quarter. No problems during this time and the person will be observed by the Program Manager during routine home observations. Any problems noted will warrant extending the time frame for the observed passes and corrective action. Continued issues would result in termination.	