

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  03/31/2015
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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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W 000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 25, 26, 27, and 31, 2015</p> <p>Facility number: 012598 Provider number: 15G800 AIM number: 201023280</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/2/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to implement</p>	W 249	All staff in the home were trained on the nutrition assessment of client #4 and the need to sit next	04/06/2015

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>a nutritional recommendation for 1 of 4 sampled clients (client #4), and to implement an objective for 1 of 4 additional clients (client #5) to wipe his mouth of excessive saliva as needed.</p> <p>Findings include:</p> <p>1. Client #4 was observed eating breakfast during the 3/26/15 observation period from 6:24 A.M. until 7:41 A.M. After his oatmeal cooled and while direct care staff #5 stood next to him, client #4 rapidly ate his oatmeal in large spoonfuls, one after another, and gulped an entire glass of milk without stopping. Direct care staff #5 did not prompt or assist client #4 in slowing the pace of his eating.</p> <p>Client #4's record was reviewed on 3/26/15 at 9:45 A.M. A review of the client's 2/19/15 nutritional assessment indicated direct care staff were to "cue to slow pace" of client #4's eating.</p> <p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "That staff (direct care staff #5) should have prompted [client #4] to slow his pace of eating."</p> <p>2. Client #5 was observed at the group</p>		<p>to him and prompt him to slow down his rate of consumption Client #4 is also to use a smaller spoon that prohibits bites that are too large Staff have been trained and have implemented the goal for client #5 to wipe his moth This is an ongoing medical issue that has been addressed over the years in various ways with no success Client #5 has had a goal in place for him to wipe his mouth Staff constantly prompt him We will ask client #5 to always carry a cloth in his pocket and attempt to teach him to wipe his moth as needed The res manager will conduct active treatment audits two time a week and document the findings making sure staff are prompting client #4 and #5 Person responsible; Res manager, QIDP</p>				

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	<p>home during the 3/25/15 observation period from 3:28 P.M. until 5:27 P.M., and the 3/26/15 observation period from 6:24 A.M. until 7:41 A.M. During the observation periods, client #5 had continuous strands of saliva dripping from his mouth. On several occasions during the observations, direct care staff prompted client #5 to wipe his mouth. However, the periodic prompting by direct care staff was not adequate as client #5 continued to drip excessive saliva onto the counter top, dining room table, and on his food during the evening and morning meals.</p> <p>Client #5's record was reviewed on 3/26/15 at 9:33 A.M. A review of the client's 1/26/15 Individual Program Plan indicated client #5 had the following objective: "[Direct care staff] are to wipe his (client #5's) mouth when he drools."</p> <p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "[client #5's] drooling is an ongoing problem. Staff (direct care staff #5) should have prompted or assisted him (client #5) in wiping his mouth."</p> <p>9-3-4(a)</p>						

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W 268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review, and interview, the facility failed to assure direct care staff interacted in a professional manner with 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>Client #4 was observed during the 3/26/15 observation period from 6:24 A.M. until 7:41 A.M. Upon entering the group home, client #4 was sitting on the couch whimpering and sobbing. Direct care staff #5 was sitting next to client #4 rubbing the client's stomach. From 6:24 A.M. until 6:58 A.M., direct care staff #5 continued to rub client #4's stomach as client #4 walked about the facility.</p> <p>Direct care staff #5 was interviewed on 3/26/15 at 7:44 A.M. When asked, direct care staff #5 stated, "He (client #4) sometimes has a hard time waking up in</p>	W 268	<p>On 4/6/15 all staff were trained on client #4's behavior support plan All staff are aware that client #4 likes to have his belly rubbed as he will place your hand on his belly in order to do so Staff were informed that this is not appropriate for them to be doing Within client #4's plan there are measures listed that staff can use to help calm client #4 An active treatment audit will be conducted two times a week by the re manager making sure that the BSP for client #4 is followed Person responsible: QID, Res manager</p>	04/06/2015

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W 295  Bldg. 00	<p>the morning and he'll cry or whimper. He will calm down if you rub his belly (stomach). He (client #4) likes it."</p> <p>Client #4's record was reviewed on 3/26/15 at 9:45 A.M. Review of the client's 11/20/14 Individual Program Plan and 1/10/15 behavior guidelines failed to indicate direct care staff were to rub the client's stomach if he were sobbing, crying, or whimpering.</p> <p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "Yeah, [client #4] likes it when his belly is rubbed but staff (direct care staff) should not be doing it."</p> <p>9-3-5(a)</p> <p>483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual</p>						

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	<p>program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on observation, record review, and interview, the facility failed to assure direct care staff did not restrain 1 of 4 sampled clients (client #4) for getting up from the dining room table.</p> <p>Findings include:</p> <p>Client #4 was observed during the 3/25/15 observation period from 3:28 P.M. until 5:27 P.M. At 4:33 P.M. direct care staff #4 prompted and assisted client #4 to sit at the dining room table for his evening meal. Client #4 sat and got up from the table three times. Each of the three times client #4 left the table, direct care staff would guide him back to his seat. The fourth time client #4 got up and left the table, direct care staff #4 forcefully grabbed the client by his left elbow and forcefully pulled him back to his seat at the dining room table.</p> <p>House manager #1 was interviewed on 3/25/15 at 5:33 P.M. When asked, house manager #1 stated, "He (client #4) gets up from the table a lot. He needs to sit down and eat his food."</p> <p>Client #4's record was reviewed on 3/26/15 at 9:45 A.M. Review of the</p>	W 295	<p>On 4/6/15 all staff were trained that it is never ok to force a person to sit down and eat meals including client #4 Staff are aware that if client #4 wants to get up from the table he may do so Staff may prompt him to come back and finish, but if he chooses not to, that is fine All staff were trained on client #4's behavior support plan that teaches no restrictive actions</p> <p>The manager and QIDP will conduct audits at least two times per week making sure that Client #4 and all others are free to move about the home as they wish</p> <p>Person responsible: QID, Res manager</p>	04/06/2015			

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W 460 Bldg. 00	<p>client's 11/20/14 Individual Program Plan and 1/10/15 behavior guidelines failed to indicate direct care staff were to forcefully restrain client #4 to his seat during meal times.</p> <p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "[Client #4] does get up a lot from the table during meal times and staff should try to guide him back to his seat, but jerking him into his seat like that is uncalled for."</p> <p>9-3-5(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 1 of 4 sampled client's (client #4's) evening meal consisted of mechanically soft foods.</p> <p>Findings include:</p>	W 460	<p>On the date of the survey client #4's food was cut into bite size pieces Staff have been re trained on the preparation of client #4's food as well as all others so that they may eat meals as prescribed by the dietician The manager and QIDP will complete meal audits at least two</p>	04/06/2015

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	<p>Client #4 was observed during the 3/25/15 observation period from 3:28 P.M. until 5:27 P.M. At 4:40 P.M. direct care staff #4 prompted and assisted client #4 to sit at the dining room table for his evening meal. Client #4 began to eat slices of pizza as direct care staff #4 was attempting to cut the pizza into smaller pieces. Client #4 grabbed and ate large 4 inch by 4 inch pieces of pizza while direct care staff struggled to cut pizza in smaller bite sized pieces.</p> <p>Client #4's record was reviewed on 3/26/15 at 9:45 A.M. Review of the client's 2/19/15 nutritional assessment indicated the client was edentulous (did not have teeth) and was on a mechanically soft diet.</p> <p>Nurse #1 was interviewed on 3/26/15 at 11:15 A.M. Nurse #1 stated, "A mechanically soft diet is one where the food is soft and cut into smaller, bite sized pieces."</p> <p>9-3-8(a)</p>		<p>times per week to make sure food is served according to diet orders Person res: QIDP, res manager</p>	

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W 473  Bldg. 00	<p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to assure oatmeal served to 1 of 4 sampled clients (client #4) was cool enough to eat.</p> <p>Findings include:</p> <p>Client #4 was observed during the 3/26/15 observation period from 6:24 A.M. until 7:41 A.M. At 7:00 A.M., Direct care staff #5 assisted client #4 in serving himself a steaming bowl of oatmeal. On three attempts to eat his oatmeal, client #4 put spoonfuls of oatmeal into his mouth and immediately spit it out. After the three attempts to eat his oatmeal, direct care staff #5, who was monitoring client #4's eating said, "What? Too hot?" After a minute of waiting, client #4 began to eat his oatmeal without difficulty. Direct care staff #5 did not assure the temperature of the oatmeal was at a proper temperature to eat when assisting client #4 in serving himself.</p> <p>Direct care staff #5 was interviewed on 3/26/15 at 7:44 A.M. Direct care staff #5 stated, "It (client #4's oatmeal) might have been a little too hot for him at first."</p>	W 473	<p>On 4/6/15 all staff were trained on serving food that is at appropriate temperatures for consumption for client #4 and all others An meal audit will be conducted at least twice a week to make sure this correction is enforced Person responsible: Manager, QIDP</p>	04/06/2015			

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W 475 Bldg. 00	<p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "His [client #4's] oatmeal should not be too hot when it is served."</p> <p>9-3-8(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation, record review, and interview, the facility failed to assure junior utensils (small sized fork, spoon, knife) were available for 2 of 4 sampled clients (clients #3 and #4).</p> <p>Findings include:</p> <p>Clients #3 and #4 were observed during the 3/26/15 observation period from 6:24 A.M. until 7:41 A.M. At 7:00 A.M., Clients #3 and #4 ate bowls of oatmeal using regular size tablespoons. Clients #3 and #4 ate their oatmeal with large spoonfuls, one after another without stopping until their servings of oatmeal</p>	W 475	<p>All staff in the home were trained on the nutrition assessment of client #3 and #4. Client #3 and 4 is are to use a smaller spoon that prohibits bites that are too large The res manager and QIDP will conduct active treatment audits two time a week and document the findings making sure staff are prompting client #3 and #4 Person responsible; Res manager, QIDP</p>	04/06/2015			

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	<p>were gone.</p> <p>Client #3's record was reviewed on 3/26/15 at 8:33 A.M. Review of the client's 3/2/15 Physician's Orders indicated client #3 was to use a "junior spoon."</p> <p>Client #4's record was reviewed on 3/26/15 at 9:45 A.M. Review of the client's 2/19/15 nutritional assessment indicated the client was to use "junior utensils."</p> <p>Director of Residential Services was interviewed on 3/26/15 at 11:15 A.M. Director of Residential Services stated, "I wasn't aware that [clients #3 and #4] were to be using junior utensils."</p> <p>9-3-8(a)</p>			