

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012	
NAME OF PROVIDER OR SUPPLIER ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 30, 31, and June 1, 2012.</p> <p>Facility number: 012436 Provider number: 15G776 AIM number: 201016860</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed on June 7, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012
NAME OF PROVIDER OR SUPPLIER ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
W0368	<p>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.</p> <p>Based on record review and interview, the facility failed to administer prescribed medications per physician's orders to 4 of 4 sampled clients living at the group home (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>The facility's incident reports from 5/30/11 to 5/30/12 were reviewed on 5/30/12 at 1:15 P.M.</p> <p>1. "Incident Date: 02/06/2012, Client: [Client #2], Narrative: It was discovered that [Client #2] did not receive both his Calcium 600 mg (milligram) supplement and his Bisoprolol 6.25 mg at 5:00 pm on 2/6/12. The calcium is taken as a supplement and the Bisoprolol is taken for treatment of high blood pressure. [Client #2's] blood pressure remains within normal limits. Plan to Resolve: Appropriate training and discipline will take place. Training will include supervised medication pass."</p> <p>2. "Incident Date: 01/15/2012, Client: [Client #3], Narrative: A medication audit revealed that [client #3] did not</p>	W0368	<p>All staff have been trained on the correct administration of medications. The facility has had no further incidents since the implementation of templates. the house is completing medication audits weekly, and once an error is made a template is put into place to prevent further concerns. The QDDP will complete weekly medication administration audits to ensure all meds are passed correctly. Will continue to follow our med administration policy. Person responsible: QDDP, Res Manager</p>	06/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012	
NAME OF PROVIDER OR SUPPLIER ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>receive his Lorazepam .5 mg (milligram) tablet on 1/15/12. Lorazepam is taken for mood stability. Since missing this dosage [client #3] has not shown any increased signs of mood instability. Plan to Resolve: Appropriate training and discipline will take place. Training will include a supervised medication pass. Standing orders of the prescribing physician were followed. For missed dosages those orders are to monitor for increased signs of mood instability. If any increase staff are to contact doctor. Since there were no signs, the doctor was not contacted. Staff are also to continue dispensing medication as prescribed."</p> <p>3. "Incident Date: 12/24/2011, Client: [Client #1], Narrative: [Client #1] went home for a visit and staff sent along prepacked medications for LOAs (Leave Of Absents) (SIC). When he (client #1) returned it was discovered that [client #1] did not receive his Lorazepam .5 mg (milligram) on 12/24 at 9 pm, 12/25 at 7 am and 9 pm, and on 12/26 at 7 am. Lorazepam is taken for mood instability. Since missing this dosage [client #1] has not shown any increased signs of mood instability. Plan to Resolve: Appropriate training and discipline will take place. Training will include a supervised medication pass. [Client #1] has gone on home visits before and his family is aware</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012	
NAME OF PROVIDER OR SUPPLIER ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>of the importance of giving medications. Standing orders of the prescribing physician were followed. For missed dosages those orders are to monitor for increased signs of mood instability. If any increase staff are to contact doctor. Since there were no signs, the doctor was not contacted. Staff are also to continue dispensing medication as prescribed."</p> <p>4. "Incident Date: 12/09/2011, Client: [Client #4], Narrative: A medication audit on 12/12/11 revealed a medication error on 12/9/11. [Client #4] did not receive his noon dose of Seroquel 200 mg (milligram). Seroquel is taken for mood stabilization. Since the missed dose of Seroquel [client #4] has not shown any increased signs of mood instability. Plan to Resolve: Appropriate training and discipline will take place. Training will include a supervised medication pass. Standing orders of the prescribing physician were followed. For missed dosages those orders are to monitor for increased signs of mood instability. If any increase staff are to contact doctor. Since there were no signs, the doctor was not contacted. Staff are also to continue dispensing medication as prescribed."</p> <p>5. "Incident Date: 08/10/2011, Client: [Client #2], Narrative: During a med (medication) audit on 8/12/11, it was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012
NAME OF PROVIDER OR SUPPLIER ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>discovered that [client #2] did not receive his complete dosage of two medications (tablets) on 8/10/11. [Client #2] should have received two Depakote 500 mg (milligram) tablets but only received one. This medication is taken as mood stabilizer. Staff report no increased evidence of mood instability. Plan to Resolve: Appropriate training and discipline will take place. Training will include a supervised medication pass. Standing orders of the prescribing physician were followed. Those orders are to continue dispensing medication as prescribed and to watch for signs of increased mood instability."</p> <p>6. "Incident Date: 8/7/2011, Client: [Client #2], Narrative: During a medication audit on 8/8/11, it was discovered that [client #2] did not receive his complete dosage of Depakote. He should have received two pills but only received one. Depakote is taken as a mood stabilizer for [client #2]. Staff report no increased mood instability. Plan to Resolve: Appropriate training and discipline will take place. Training will include a supervised medication pass. Standing orders of the prescribing physician of the Depakote were followed. Those orders are to continue dispensing medication as ordered and monitor for increased signs of mood instability."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2012	
NAME OF PROVIDER OR SUPPLIER ADEC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
	<p>Client #1's 11/20/11 physician orders were reviewed on 5/31/12 at 8:35 A.M. The review indicated the following order: "Lorazepam 0.5 mg tablet, Give 1 tablet orally 2 times a day."</p> <p>Client #2's 4/15/11 and 1/15/12 physician orders were reviewed on 5/31/12 at 8:05 A.M. The review of the 4/15/11 orders indicated the following: "Divalproex Sod(generic for Depakote) ER (Extended Release) 500 mg tab, 2 tabs every evening at supper." Review of the client's 1/15/12 orders indicated the following: Bisoprolol-HCTZ (Hydrochlorithiazide) 5-6.25 mg tab, 1 tab (tablet) daily" and "Calcium 500 + D (vitamin D), 1 tab orally 2 times a day."</p> <p>Client #3's 11/20/11 physician orders were reviewed on 5/31/12 at 9:30 A.M. The review indicated the following orders: "Lorazepam 0.5 mg tablet, Give 1 tablet orally 2 times a day."</p> <p>Client #4's 11/20/11 physician orders were reviewed on 5/31/12 at 9:49 A.M. The review indicated the following orders: "Seroquel 200 mg tablet, Give 1 tablet orally 3 times a day."</p> <p>Program Director #1 was interviewed on 5/31/12 at 10:26 P.M. Program Director</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G776	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 52035 TARA DR SOUTH BEND, IN 46628
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	#1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." 9-3-6(a)			