STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G221	A. BUILDING 00 B. WING	05/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEC INC	59796 PARK SIDE ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	This visit was for an annual fundamental recertification and state licensure survey. Dates of Survey: May 15, 16, 17, and 18, 2012 Facility number: 000745 Provider number: 15G221 AIM number: 100234850 Surveyor: Tracy Brumbaugh, Medical Surveyor III These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed on 5/29/12 by Tim Shebel, Medical Surveyor III.	W0000		

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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W0149	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 record review and interview, the facility failed for 1 of 8 clients (client #5) to ensure the facility's abuse/neglect policy was implemented for 1 of 1 Bureau of Developmental Disability Services (BDDS) reports which involved financial exploitation. Findings include: On 5-15-12 at 11:45 a.m. a review of the Facility's BDDS reports was conducted. A BDDS report for client #5 dated 9-15-12 indicated $48.45 of her money had been used to mail a package to her grandfather. During the investigation it was determined the House Manger had used client #5's money to purchase a card, a stamp and to mail a package to South Korea. The House Manager was suspended, then terminated and client #5 was refunded the money on 9-20-11. On 5-15-12 at 10:00 a.m. a review of the facility's Abuse/Neglect policy dated 8-29-07 indicated clients would not be subjected to abuse, neglect or exploitation. On 5-16-12 at 12:30 p.m. an interview with the Facility Director indicated the abuse/neglect policy should be implemented by staff and the House Manager violated the abuse/neglect policy and was terminated. 9-3-2(a)	W0149	Per agency policy, the staff member was terminated for her actions.Once a fund audit was completed, the Director was notified of the incident and promptly investigated.All facility staff are trained on the abuse/neglect/exploitation policy on at least an annual basis.Person Responsible: DRO	06/05/2012

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #3) to ensure medication goals per the Individualized Support Plan were implemented at all times of opportunity. On 5-16-12 at 7:17 a.m. client #1 was observed during her medication administration with assistance from direct care staff #1. Direct care staff (dcs) #1 punched out client #1's medications onto a template, dcs #1 pointed to the medications on the template and asked client #1 if they were her medications. Client #1 then took her Seroquel XR 400 mg for schizophrenia, Lexapro 20 mg for depression, Hydrochlorathiazide 25 mg for blood pressure, and Detrol 2 mg for urinary incontinence with water. Dcs #1 did not prompt client #1 to state the names of her medications. On 5-16-12 at 9:30 a.m. a record review for client #1 was conducted. The IPP dated 12-1-12 indicated client # had a goal/objective to state the names of her medication taken. On 5-16-12 at 7:46 a.m. client #3 was observed during her medication administration with assistance from dcs #1. Dcs #1 punched client #3's medications from the bubble packs onto a template, asked client #3 if they were her pills. Client #3 took her Benztropine MES 1 mg for side effects, Risperidone 2 mg for mood, Topiramate	W0249	On 5/22/12 all staff was trained on running goals on both a formal and informal basis. Staff were specifically trained on med administration goals and the importance of running the goals at all opportunities. In order to prevent this in the future, the QDDP and Res Manager will complete weekly medication observations to make sure goals are being completed. Failure to comply will result in disciplinary actionPerson Responsible: QDDP, Res Manager	06/05/2012

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	100 mg for seizures, Calcium 500 mg with vitamin D for nutrition, Cymbalta 60 mg for depression with water, and Tobramycin 0.3% eye drops for a sty. Dcs #1 did not prompt client #3 to use sign language to determine the number of pills she had taken at her medication administration. On 5-16-12 at 10:10 a.m. a record review for client #3 was conducted. The IPP dated 1-5-12 indicated client #3 was to use sign language to indicate the number of pills taken at her medication administration. On 5-16-12 at 12:30 p.m. an interview with the Facility Director indicated medication administration goals should be run at all times of opportunity. 9-3-4(a)			

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W0268	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 and interview, the facility failed for 1 of 1 clients (client #5) who used a urinary incontinence chair protector, to ensure the urinary product was not visible to all who entered the home. Findings include: On 5-15-12 at 4:25 p.m. client #5 sat in a recliner with a urinary incontinence product covering the seat. Dcs #1 indicated the urinary product was placed on the chair for client #5. On 5-16-12 at 5:45 a.m. client #5 sat in the recliner with a urinary incontinence product which covered the seat area. From 5:45 a.m. until 7:05 a.m. client #5 sat only in the recliner with the urinary incontinence product on it in her living room. On 5-16-12 at 12:30 p.m. an interview with the Facility Director indicated the urinary incontinence pad should not be seen and it did not promote dignity and respect for client #5. 9-3-4(a)	W0268	On 5/22/12 all staff were trained on respect and dignity issues including having client #5 sit on an incontinence pad. Client #5 is to use the restroom regularly and have her undergarments changed as needed to prevent any soiling of furniture.In order to prevent this in the future, the QDDP will conduct weekly observations to make sure that this practice has been eliminated. Failure to comply will result in disciplinary action.Person Responsible: QDDP	06/05/2012

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W0362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) to ensure pharmacy drug regimens were completed at least quarterly. Findings include: On 5-16-12 at 12:15 p.m. a record review of the facility's pharmacy reviews was conducted for clients #1, #2, #3, #4, #5, #6, #7, and #8. The review indicated the last review was in August 2011. November 2011 and February 2012 had not been completed and were not available for review. On 5-16-12 at 12:30 p.m. an interview with the Facility Director indicated there were no pharmacy reviews available for review since the one in August 2011 and reviews should be done quarterly. 9-3-6(a)	W0362	On 5/16/12 the pharmacy was called and informed of the error. They presented the Director with an updated schedule of quarterly pharmacy review dates as well as sent a pharmacist out to the home to complete the reviews on 5/16/12. The director spoke to the head pharmacist and explained the importance of doing this timely. The Health Service Coordinator was trained on following up with the pharmacy and looking for such required documents. It is the intention of the facility to find a new provider of pharmacy services. The HSC will contact the pharmacy for the required reports on a quarterly basis.Person Responsible: HSC, DRO	06/05/2012

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W0449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview, the facility failed to ensure 1 of 8 clients (client #5) who lived in the home, to ensure all problems with evacuation drills were investigated. On 5-15-12 at 9:20 a.m. a record review of the facility's evacuation goals was conducted. The review indicated client #5 refused to participate in the following evacuation drills: 6-25-11, 8-20-11, 3-7-12, 3-11-12, 3-20-12, 4-12-12, 4-14-12 and 5-8-12. On 5-16-12 at 9:00 a.m. a record review for client #5 was conducted. The IPP dated 4-24-12 did not include a goal/objective to assist client #5 with her refusals to participate in emergency evacuation drills. On 5-16-12 at 12:30 p.m. an interview with the Facility Director indicated she did not see a goal in the IPP to assist client #5 with his refusals of evacuation drills. 9-3-7(a)	W0449	On 5/22/12 all facility staff were trained on the goal put into place for client #5 and her refusal to participate in fire drills. In the future, if there is a pattern of fire drill refusals, the QDDP will address the need for a formal goal. The QDDP will continue to review all fire drills once they are complete.Failure to comply will result in disciplinary action.Person Responsible: QDDP	06/05/2012