

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G510	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/22/2013
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NAME OF PROVIDER OR SUPPLIER  ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 226 FOSTER AVE ELKHART, IN 46516
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: July 17, 18, 19, and 22, 2013</p> <p>Facility Number: 001024 Provider Number: 15G510 AIM Number 100249450</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/25/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when being prepared for administration for 3 of 4 sampled clients (clients #1, #2, and #4) and 4 of 4 additional clients (clients #5, #6, #7 and #8).</p> <p>Findings include:</p> <p>Direct care staff #7 was observed passing medications during the 7/18/13 observation period from 5:53 A.M. until 8:00 A.M.. At 6:03 A.M., direct care staff #7 prepared medications for client #3. Direct care staff #7 then exited the medication room to get a glass of water for client #3. Direct care staff #7 was out of the office for 20 seconds and had left the client's medication on the desk, unsecured. The medications that were left unlocked were accessible to clients #1, #2, #4, #5, #6, #7, and #8.</p> <p>Program Director #1 was interviewed on 7/18/13 at 10:55 A.M. Program Director #1 indicated direct care staff should have had all medications locked when staff were not in the medication room.</p>	W000382	All staff were trained to never leave medications unattended. Staff were trained to lock the medication room when they have to leave the area. In order to prevent this in the future, the QIDP will complete weekly monitoring of medication administration to make sure the deficient practice has been corrected. Failure to comply will result in disciplinary action.	07/29/2013

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	9-3-6(a)			

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>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 maintain the oxygen cannula in an aseptic manner for 1 of 1 client utilizing an oxygen cannula (client #5.)</p> <p>Findings include:</p> <p>Client #5 was observed during the group home observation period on 7/18/13 from 5:53 A.M. until 8:00 A.M.. At 7:53 A.M., client #5, while wearing a nasal cannula for oxygen, rose from sitting on the couch and took off his nasal cannula and threw it on the floor. Client #4, who was walking across the living room, stepped on the nasal cannula and direct care staff #9 picked it up and placed it on the couch. Direct care staff #7, who was also in the living room, directed client #5 back to the couch and put his nasal cannula back on the client. Direct care staff did not sanitize the client's nasal cannula prior to putting it back on the client's nose.</p> <p>Program Director #1 was interviewed on 7/18/13 at 10:55 A.M.. Program Director #1 indicated direct care staff #7 should have assured sanitary conditions for client</p>	W000455	<p>Staff have been trained to sanitize client #5's nasal cannula if it is dropped to the floor. The QDIP has a goal in place for client #5 to wear his oxygen. The O2 is now affixed to a clip that is clipped to his shirt so that the tubing cannot touch the floor. The QDIP will complete weekly monitoring to make sure the defficient practice is corrected. Failure to comply will result in disciplinary action.</p>	07/29/2013			

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	#5's nasal cannula prior to putting it back onto the client's nose. 9-3-7(a)				