

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G485	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2011
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 403 HAWTHORNE AVE GOSHEN, IN46526
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W0000	<p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: December 5, 6, and 7, 2011.</p> <p>Facility number: 000999 Provider number: 15G485 AIM number: 100239770</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/QMRP-Team Leader Tim Shebel, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/14/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0157	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement effective corrective actions for 8 of 8 reviewed medication administration errors which</p>	W0157	<p>On 12/13/11 all facility staff were trained on an additional compliance check that is required during all medication passes. One staff will be assigned to the medication administration, and responsible for all compliance</p>	12/13/2011

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>affected 5 of 8 clients living at the group home (clients #1, #2, #4, #6, and #7).</p> <p>Findings include:</p> <p>The facility's incident reports from 12/5/10 to 12/5/11 were reviewed on 12/5/11 at 12:08 P.M..</p> <p>1. "Incident Date: 04/03/2011, Client: [Client #1], Narrative: [Client #1] received one Zoloft (anti-depression medication) instead of two, her antidepressant (sic). There has not been an increase in signs and symptoms of her depression since the missed dose. This was discovered during a routine med (medication) audit. ADEC staff will continue audits, and staff was disciplined using ADEC's medication error policy and was reminded to follow the steps taught in Core A (medication administration curriculum.)"</p> <p>2. "Incident Date: 04/17/2011, Client: [Client #7], Narrative: On 4/17/2011 [client #7] only received half the dose of her Baclofen (muscle relaxer) 20mg (milligrams) ordered dose. There has not been an increase in muscle tension since the missed dose. No further doctor recommendations at this time. The staff that made the medication error will be disciplined using ADEC's med error</p>		<p>checks. Once the medication is ready to be administered staff B will check the medications and MAR for compliance. Only after the staff B checks the medications, will they be given to the resident. If an error is made, both staff members will be disciplined according to policy. If there is an error with the two staff process, a template will be instituted. With the template there will be the two staff compliance, but staff will be required to place each pill on a template and match them to the MAR. Failure to pass medications without error will result in disciplinary action according to agency policy.</p> <p>PERSONS RESPONSIBLE: Nurse, Program Manager, Residential Manager, Facility Staff.</p>		

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	<p>policy and procedures. All ADEC staff have been trained using the Core A curriculum."</p> <p>3. "Incident Date: 05/11/2011, Client: [Client #1], Narrative: [Client #1] received one half dose of Lorazepam (tranquilizer). After close monitoring it was determined client had her usual evening and following day with no signs of increased anxiety. Appropriate discipline and training has occurred. Continue to emphasize need for three compliance checks as is taught in Core A and Core B (medication administration curriculum.)"</p> <p>4. "Incident Date: 06/05/2011, Client: [Client #6], Narrative: During an audit it was discovered that [client #6] did not receive the correct dosage of Keppra (anti-seizure medication) 500 mg on 6/5/11. [Client #6] is only to receive one pill but was given two. Staff did not notice any of the side effects listed for over medicating. Appropriate discipline and training will take place."</p> <p>5. "Incident Date: 06/18/2011, Client: [Client #1], Narrative: During a med audit on 6/20/11, it was discovered that [client #1] did not receive her complete dose of Lamotrigine (anti-seizure medication) 150 mg. She should get two</p>				

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	<p>pills but only received one. [Client #1] takes this medication for seizures. Since missing the pill, [client #1] has not had any seizure activity. Appropriate training and discipline will take place. Training will include a supervised med pass on the staff's next assigned med pass."</p> <p>6. "Incident Date: 09/23/2011, Client: [Client #2], Narrative: During morning med pas on 9/23/11 [client #2] had received and (sic) extra dose of Sertraline (anti-depression medication) 100mg tab. This medication is taken for depression. There were no negative outcomes for the extra dose. No recommendations at this time from the physician. Re-training of staff involved implementation of the medication error disciplinary policy."</p> <p>7. "Incident Date: 09/28/2011, Client: [Client #6], Narrative: A med audit on 9/29/11 showed that [client #6] did not receive her complete dosage of Adderall (attention deficit hyperactivity medication) 20mg. She should have received two pills but only received one. Standing orders of the prescribing physician were followed. Those orders are to continue giving the medications as prescribed and monitor for side effects. None were noted. Appropriate training and discipline will take place. Training will include a supervised medication</p>				

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	<p>pass."</p> <p>8. "Incident Date: 11/20/2011, Client: [Client #4], Narrative: On 11/20/11 [client #4] did not receive her complete dose of Citrucel 500mg fiber tablets (stool softener.) Citrucel is taken as a stool softener. Since missing the dosage [client #4] has not showed any signs of having difficult bowel movements. No recommendations from PCP (primary care physician.) Re-training of staff involved and (sic) implementation of the medication error disciplinary policy."</p> <p>Nurse #1 was interviewed on 12/6/11 at 1:26 P.M.. Nurse #1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." Nurse #1 further stated the "medication errors just continued even after the staff had been disciplined and retrained."</p> <p>9-3-2(a)</p>				

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W0327	<p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Based on record review and interview, the facility failed to document tuberculosis control testing in millimeter duration for 2 of 4 sampled clients (clients #1 and #2) who lived in the home.</p> <p>Findings include:</p> <p>On 12/6/11 at 11:30am, client #1's record was reviewed. Client #1's 5/2011 mantoux/tuberculosis control testing indicated the results were "not significant" but were not recorded or measured in millimeters. Client #1's 1/17/11 History and Physical signed by client #1's personal physician did not include testing for tuberculosis control.</p> <p>On 12/6/11 at 10:55am, client #2's record review was reviewed. Client #2's 5/27/11 mantoux/tuberculosis control testing indicated results were "not significant" but were not recorded or measured in millimeters. Client #2's 2/22/11 History and Physical signed by client #2's personal physician did not include testing</p>	W0327	<p>On 12/12/11 the Health Service Coordinator inserviced all staff that administer TB tests an inservice on appropriate documentation of findings. Staff were informed that they must document in "mm" not by writing "not significant." Nursing staff will review each TB test that is administered ensuring correct documentation and initialing the form. The individual who documented incorrectly no longer is employed at the agency. Failure to comply will result in disciplinary action. PERSON RESPONSIBLE: Nursing staff</p>	12/12/2011

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W0368	<p>for tuberculosis control.</p> <p>On 12/6/11 at 1:55pm, an interview with the Residential Director of Operations (RDO) and LPN (Licensed Practical Nurse) #1 was completed. The RDO and LPN #1 both stated clients #1 and #2's tuberculosis control testing "should have been read in millimeters and was not." The agency's policy and procedure for tuberculosis control testing was requested for review.</p> <p>On 12/7/11 at 9:20am, an interview with the RDO was completed and the RDO indicated no further information was available for review. No policy/procedure for tuberculosis control testing was available for review.</p> <p>9-3-6(a)</p> <p>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 5 of 8 clients living at the group home (clients #1, #2, #4, #6, and #7).</p> <p>Findings include:</p> <p>The facility's incident reports from</p>	W0368	<p>On 12/13/11 all facility staff were trained on an additional compliance check that is required during all medication passes. One staff will be assigned to the medication administration, and responsible for all compliance checks. Once the medication is ready to be administered staff B will check the medications and MAR for compliance. Only after the staff B checks the</p>	12/13/2011	

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	<p>12/5/10 to 12/5/11 were reviewed on 12/5/11 at 12:08 P.M..</p> <p>1. "Incident Date: 04/03/2011, Client: [Client #1], Narrative: [Client #1] received one Zoloft (anti-depression medication) instead of two, her antidepressant. There has not been an increase in signs and symptoms of her depression since the missed dose. No Doctor recommendations. This was discovered during a routine med (medication) audit. ADEC staff will continue audits, and staff was disciplined (sic) using ADEC's medication error policy and was reminded to follow the steps taught in Core A (medication administration curriculum.)"</p> <p>2. "Incident Date: 04/17/2011, Client: [Client #7], Narrative: On 4/17/2011 [client #7] only received half the dose of her Baclofen (muscle relaxer) 20mg (milligrams) ordered dose. There has not been an increase in muscle tension since the missed dose. No further doctor recommendations at this time. The staff that made the medication error will be disciplined using ADEC's med error policy and procedures. All ADEC staff have been trained using the Core A curriculum."</p> <p>3. "Incident Date: 05/11/2011, Client:</p>		<p>medications, will they be given to the resident. If an error is made, both staff members will be disciplined according to policy. If there is an error with the two staff process, a template will be instituted. With the template there will be the two staff compliance, but staff will be required to place each pill on a template and match them to the MAR. Failure to pass medications without error will result in disciplinary action according to agency policy.</p> <p>PERSONS RESPONSIBLE: Nurse, Program Manager, Residential Manager, Facility Staff.</p>		

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	<p>[Client #1], Narrative: [Client #1] received one half dose of Lorazepam (tranquilizer). After close monitoring it was determined client had her usual evening and following day with no signs of increased anxiety. Appropriate discipline and training has occurred. Continue to emphasize need for three compliance checks as is taught in Core A and Core B (medication administration curriculum.)"</p> <p>4. "Incident Date: 06/05/2011, Client: [Client #6], Narrative: During an audit it was discovered that [client #6] did not receive the correct dosage of Keppra (anti-seizure medication) 500 mg on 6/5/11. [Client #6] is only to receive one pill but was given two. Staff did not notice any of the side effects listed for over medicating. Appropriate discipline and training will take place."</p> <p>5. "Incident Date: 06/18/2011, Client: [Client #1], Narrative: During a med audit on 6/20/11, it was discovered that [client #1] did not receive her complete dose of Lamotrigine (anti-seizure medication) 150 mg. She should get two pills but only received one. [Client #1] takes this medication for seizures. Since missing the pill, [client #1] has not had any seizure activity. Appropriate training and discipline will take place. Training</p>				

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	<p>will include a supervised med pass on the staff's next assigned med pass."</p> <p>6. "Incident Date: 09/23/2011, Client: [Client #2], Narrative: During morning med pas on 9/23/11 [client #2] had received and (sic) extra dose of Sertraline (anti-depression medication) 100mg tab. This medication is taken for depression. There were no negative outcomes for the extra dose. No recommendations at this time from the physician. Re-training of staff involved implementation of the medication error disciplinary policy."</p> <p>7. "Incident Date: 09/28/2011, Client: [Client #6], Narrative: A med audit on 9/29/11 showed that [client #6] did not receive her complete dosage of Adderall (attention deficit hyperactivity medication) 20mg. She should have received two pills but only received one. Standing orders of the prescribing physician were followed. Those orders are to continue giving the medications as prescribed and monitor for side effects. None were noted. Appropriate training and discipline will take place. Training will include a supervised medication pass."</p> <p>8. "Incident Date: 11/20/2011, Client: [Client #4], Narrative: On 11/20/11 [client #4] did not receive her complete</p>				

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	<p>dose of Citrucel 500mg fiber tablets (stool softener.) Citrucel is taken as a stool softener. Since missing the dosage [client #4] has not showed any signs of having difficult bowel movements. No recommendations from PCP (primary care physician.) Re-training of staff involved and (sic) implementation of the medication error disciplinary policy."</p> <p>Client #1's 11/11/11 physician orders were reviewed on 12/6/11 at 12:03 P.M.. The review indicated the following orders: "Lamotrigine 150 mg tablet, Give 2 tablets {300mg} orally 2 times a day. Sertraline HCL (Zoloft) (hydrochloride) 100 mg tablet, Give 2 tablets orally every morning. Lorazepam 1 mg tablet, Give 1 tablet orally 3 times a day."</p> <p>Client #2's 11/11/11 physician orders were reviewed on 12/6/11 at 12:09 P.M.. The review indicated the following orders: "Sertraline HCL 100 mg tablet, Give 1 tablet orally once a day."</p> <p>Client #4's 11/11/11 physician orders were reviewed on 12/6/11 at 12:12 P.M.. The review indicated the following orders: "SM Fiber laxative (Citrucel) 500 mg, Give 2 tablets orally once a day."</p> <p>Client #6's 11/11/11 physician orders were reviewed on 12/6/11 at 12:16 P.M..</p>				

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	<p>The review indicated the following orders: "Levetiracetam (Keppra) 500 mg tablet, Give 1 tablet orally 2 times a day. Amphetamine Salts (Adderall) 20 mg tablet, Give 1 tablet orally 3 times a day."</p> <p>Client #7's 11/11/11 physician orders were reviewed on 12/6/11 at 12:22 P.M.. The review indicated the following orders: "Baclofen 10 mg tablet, Give 2 tablets via G-tube (feeding tube) at bedtime."</p> <p>Nurse #1 was interviewed on 12/6/11 at 1:26 P.M.. Nurse #1 stated continued medication administration errors were the result of "new staff and just staff committing med errors." Nurse #1 further stated the "medication errors just continued even after the staff had been disciplined and retrained."</p> <p>9-3-6(a)</p>				