

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 LONGWOOD CT GOSHEN, IN 46526
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 7, 8, 9, 10, and 11, 2014</p> <p>Facility number: 000641 Provider number: 15G103 AIMS number: 100234120</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 4/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>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 to implement their abuse/neglect policy to have evidence the administrator (Residential Director) was notified of the findings of 1 of 1 reviewed investigation of alleged abuse involving 1 of 4 additional clients (client #5).</p> <p>Findings include:</p>	W000149	<p>On 4/11/14 all facility staff were again trained on the agency abuse/neglect/exploitation policy. Staff were informed of the requirement to report the issue immediately to the administrator/ ADEC Human Rights Representative or to APS. In order to continue refreshing staff knowledge of the policy, it will be reviewed with all facility</p>	04/14/2014

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>The facility's records were reviewed on 4/7/14 at 9:10 A.M.. The following incident of alleged abuse was reviewed:</p> <p>- "Name: [Client #5], Incident Date: 12/23/2013, Date of Knowledge: 12/26/2013 Narrative: It was reported that [direct care staff #7] made comments with the intent to embarrass or humiliate [client #5]. After [client #5] used the rest room and his underwear was observed to be wet, [direct care staff #7] was reported to have said, 'I can't believe he (client #5) [derogatory word for urinating] himself when I just woke him up.' Also, while [client #5] was getting ready to shower, [direct care staff #7] is reported to have brought another client into the restroom while [client #5] was undressing. For this investigation, interviews and written statements were obtained from [direct care staff #7, direct care staff #8], second staff on duty, and [manager #1], manager of the group home. [Direct care staff #7 and direct care staff #8] were the only staff present at the time of the incident. [Direct care staff #8] reported that she was in [client #5's] room assisting his room mate when [client #5] came in from using the restroom. [Client #5] noticed his under wear was wet and wanted to shower. [Direct care staff #7] stated, 'I can't believe he (client #5) [derogatory</p>		<p>staff monthly. The QIDP will also conduct weekly random staff interviews asking what one would do if they became aware of Abuse/neglect or exploitation. Failure to comply will result in disciplinary action. Person Responsible: QIDPADDENDUM: The person responsible for verbal abuse was terminated at that time. There have been no further incidences since he left. During the interviews about reporting, the QIDP also spends time at the house monitoring. The res manager is at the home daily monitoring staff behavior to those who live there.</p>		

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	<p>word for urinating] himself when I just woke him up.' [Direct care staff #7] first refused to allow [client #5] to take a shower to clean up, but relented when [client #5] got upset. When [client #5] was getting undressed to get into the shower, [direct care staff #7] brought in another client to use the restroom. [Direct care staff #7] was interviewed. He stated that [client #5] was taken to the restroom after getting out of bed and returned to his room after. [Direct care staff #7] stated that it is after returning to room, [client #5] intentionally urinated. [Direct care staff #7] stated that this is a behavior that [client #5] exhibits regularly. [Direct care staff #7] stated that he did not take anyone to the restroom occupied by [client #5] until [client #5] was dressed. [Direct care staff #7] stated that a timer is set for [client #5] so his timely with his shower. [Direct care staff #7] did admit to saying 'I can't believe he [client #5] [derogatory word for urinating] himself when I just woke him up.' He (direct care staff #7) denies saying it around clients. House Manager, (manager #1), was asked about [client #5] having a behavior of urinating to get the attention of new staff or when upset. She (manager #1) stated that there was a time when he did but that has not happened in quite some time. A review of [client #5's] behavior plan shows that</p>			

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	<p>this is not a targeted behavior being tracked for [client #5]. The allegation is substantiated. [Direct care staff #7] remains suspended and has not worked since the allegations were made. Disciplinary action will take place after the New Year's Day shutdown."</p> <p>The facility's records were further reviewed on 4/7/14 at 11:07 A.M. A review of the investigation of the aforementioned 12/23/13 allegation of abuse indicated the administrator was not notified of the allegation until 12/26/13. Further review of the investigative findings of 12/23/13 alleged abuse incident indicated direct care staff #7 was terminated from employment with the facility on 1/3/14.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/7/14 at 12:23 P.M. QIDP stated, "Yes, the administrator was not notified (of the 12/23/13 allegation of abuse of client #5) until December 26th (2013)."</p> <p>The facility's records were further reviewed on 4/7/14 at 1:58 P.M. Review of the facility's "Incident Reporting and Management Policy (Abuse/Neglect Policy)", dated 12/21/11, indicated, in part, the following: "Any employee who has reasonable suspicion of a possible</p>						

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W000153	<p>case of abuse, neglect, or financial exploitation of a client by anyone including other clients shall immediately report it verbally to the ADEC Human Rights Officer or designee."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to have evidence the administrator (Residential Director) was notified of the findings of 1 of 1 reviewed investigation of alleged abuse involving 1 of 4 additional clients (client #5).</p> <p>Findings include: The facility's records were reviewed on 4/7/14 at 9:10 A.M.. The following incident of alleged abuse was reviewed: - "Name: [Client #5], Incident Date: 12/23/2013, Date of Knowledge: 12/26/2013 Narrative: It was reported</p>	W000153	<p>On 4/11/14 all facility staff were again trained on the agency abuse/neglect/exploitation policy. Staff were informed of the requirement to report the issue immediately to the administratotr/ ADEC Human Rights Representative or to APS. In order to continue refreshing staff knowledge of the policy, it will be reviewed with all facility staff monthly. The QIDP will also conduct weekly random staff ionterviewes asking what one would do if they became aware of Abuse/neglect or exploitation. Failure to comply will result in disciplinary action. Person Responsible: QIDPADDENDUM: The person responsible for verbal</p>	04/14/2014

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	that [direct care staff #7] made comments with the intent to embarrass or humiliate [client #5]. After [client #5] used the restroom and his underwear was observed to be wet, [direct care staff #7] was reported to have said. 'I can't believe he (client #5) [derogatory word for urinating] himself when I just woke him up.' Also, while [client #5] was getting ready to shower, [direct care staff #7] is reported to have brought another client into the restroom while [client #5] was undressing. For this investigation, interviews and written statements were obtained from [direct care staff #7, direct care staff #8], second staff on duty, and [manager #1], manager of the group home. [Direct care staff #7 and direct care staff #8] were the only staff present at the time of the incident. [Direct care staff #8] reported that she was in [client #5's] room assisting his room mate when [client #5] came in from using the restroom. [Client #5] noticed his underwear was wet and wanted to shower. [Direct care staff #7] stated, 'I can't believe he (client #5) [derogatory word for urinating] himself when I just woke him up.' [Direct care staff #7] first refused to allow [client #5] to take a shower to clean up, but relented when [client #5] got upset. When [client #5] was getting undressed to get into the shower, [direct care staff #7] brought in		abuse was terminated at that time. There have been no further incidences since he left. During the interviews about reporting, the QIDP also spends time at the house monitoring. The res manager is at the home daily monitoring staff behavior to those who live there.		

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	<p>another client to use the restroom. [Direct care staff #7] was interviewed. He stated that [client #5] was taken to the restroom after getting out of bed and returned to his room after. [Direct care staff #7] stated that it is after returning to room, [client #5] intentionally urinated. [Direct care staff #7] stated that this is a behavior that [client #5] exhibits regularly. [Direct care staff #7] stated that he did not take anyone to the restroom occupied by [client #5] until [client #5] was dressed. [Direct care staff #7] stated that a timer is set for [client #5] so his timely with his shower. [Direct care staff #7] did admit to saying 'I can't believe he [client #5] [derogatory word for urinating] himself when I just woke him up.' He (direct care staff #7) denies saying it around clients. House Manager, (manager #1), was asked about [client #5] having a behavior of urinating to get the attention of new staff or when upset. She (manager #1) stated that there was a time when he did but that has not happened in quite some time. A review of [client #5's] behavior plan shows that this is not a targeted behavior being tracked for [client #5]. The allegation is substantiated. [Direct care staff #7] remains suspended and has not worked since the allegations were made. Disciplinary action will take place after the New Year's Day shutdown."</p>			

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W000369	<p>The facility's records were further reviewed on 4/7/14 at 11:07 A.M. A review of the investigation of the aforementioned 12/23/13 allegation of abuse indicated the administrator was not notified of the allegation until 12/26/13. Further review of the investigative findings of 12/23/13 alleged abuse incident indicated direct care staff #7 was terminated from employment with the facility on 1/3/14.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/7/14 at 12:23 P.M. QIDP stated, "Yes, the administrator was not notified (of the 12/23/13 allegation of abuse of client #5) until December 26th (2013)."</p> <p>9-3-2(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 21 observed administered medications were administered according to physician's orders for 1 of 4 sampled</p>	W000369	On 4/11/14 client #2's physician clarified his calcium order to read, "one tablet with food bid. Client #2's MAR was updated at that time and all staff were trained on the order as well as what constitutes taking the medication	04/11/2014

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	<p>clients (client #2).</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation period on 4/8/14 from 3:10 P.M. until 5:15 P.M. At 4:13 P.M., direct care staff #4 administered one tablet of "Calcium Carbonate, 600 milligram tablet" to client #2. During the 4/8/14 observation period, client #2 was not observed to eat a meal.</p> <p>Client #2's record was reviewed on 4/8/14 at 5:15 P.M. Review of client #2's 2/13/14 physician's orders indicated the following order: "Calcium Carbonate 600mg (milligram) tablet, 1 tab (tablet) PO (by mouth) BID (twice a day) with meals for nutritional supplement."</p> <p>Nurse #1 was interviewed on 4/9/14 at 8:11 A.M. Nurse #1 stated, "[Client #2's] Calcium Carbonate medication should have been administered with a meal."</p> <p>9-3-6(a)</p>		<p>with food. The new med times are 7am, where he will take the medication with breakfast, and 4pm where he will take the medication with a choice of a variety of food items prior to dinner. In order to prevent this in the future, a weekly medication administration audit will be completed by the LPN, QIDP or Res. Manager. Failure to comply will result in disciplinary action. Person Responsible: QIDP, Res Manager, LPN</p>		