

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 02/21/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 403 HAWTHORNE AVE 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: February 17, 18, 19, 20, and 21, 2014.</p> <p>Facility number: 000999 Provider number: 15G485 AIM number: 100239770</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 2/28/14 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 neglected, for 6 of 6 reviewed incidents, to implement their abuse/neglect policy to protect 1 of 4 sampled clients (client #3) from pulling out her G-tube (gastric tube) while at the facility owned day program and the group home.</p>	W000149	<p>On 3/7/14 the QIDP will be trained on interventions required in order to prevent client #3 from pulling out her g-tube. Focus of the training will be ensuring that all staff at home and day program are following the same plan. As far as interventions, the facility implemented techniques that would slow client #3 down when</p>	03/07/2014

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>Findings include:</p> <p>The facility's records were reviewed on 2/17/14 at 9:13 A.M.. The review indicated the following incidents of client #3 pulling out her G-tube.</p> <p>1. "Name: [Client #3], Date: 10/01/2013, Narrative: [Client #3] pulled her G-tube out at day program. 2) no feeding in process, 3) grabbed out by self at the end of vocational hour AFTER announcing to staff at 10:45am that she wanted to go home.... . Plan to Resolve: [Client #3] will see Gastroenterologist as soon as possible for recommendations; will see Psychiatrist as soon as possible for recommendations; will be returned to day program following any G-tube related ER visit and will earn daily, 10 min (minutes) of 1 on 1 time (one staff with client #3) with SGL (Supervised Group Living) staff if she has not pulled the G-tube out at day program."</p> <p>2. "Name: [Client #3], Date: 09/24/2013, Narrative: [Client #3] was in her 1) base room at day services, 2) not in the feeding process, and was 3) on her computer. The usual staff in the room were keeping an eye on [client #3] while assisting other clients with a</p>		<p>she is upset and wanting to pull her g-tube out. As per her behavior support plan, this is an attention seeking behavior. The team discussed further measures other than the abdominal binder and found them to fall within the category of restraint of which the facility could not implement. Client #3 is very quick and even with the binder on is able to pull her tube out. Resident #3 expresses no pain when this occurs. In the future, if staff observe any triggers that cause client #3 to pull her tube out, all staff in the house and at day program will be notified and a staffing plan put into place that will increase staff physical presence during these times in order to prevent her from pulling the tube out. If there is an issue of incidents for any individual in the home, the risk management team will review to prevent future occurrences. Staff will watch client #3 closely on a daily basis looking for triggers. The QIDP will retrain all staff that work with client #3 on her BSP. Person Responsible: QIDPADDENDUM: The abdominal binder can only be worn one way and that is wrapping across her stomach covering the gtube and Velcro in the back. Client #3 will reach over and under to pull her tube out when she wants to. As noted above, when we notice triggers, staff will be increased to the level of 1:1 to try to prevent this from</p>				

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	<p>vocational activity. [Client #3] is usually content at her computer and able to focus as opposed to her mind and body wandering. One of the DSPs (Day Services Professional) saw something fly across the room from [client #3's] direction-- it was the G-tube that she had pulled out. SGL staff were notified immediately, [client #3] was taken to ER at [local hospital] and a new tube inserted by the ER physician. There were no further orders from the physician.... . Plan to Resolve: [Client #3's] BSP (Behavior Support Plan) includes self-injurious behavior and the plan is being followed. [Client #3] did have her binder on (elastic band that covers and hinders client #3's access to her G-tube), though it does not prevent her from pulling tube out. New plans to prevent future incidents will be sent via a follow-up to this report."</p> <p>3. "Name: [Client #3], Date: 8/29/2013, Narrative: [Client #3] Stood up in her day program room and promptly pulled out her G-tube. SGL staff was called and took [client #3] to ER where a new tube was inserted. She was discharged from ER back to SGL. [Client #3] was wearing an abdominal binder at the time she pulled the tube today. Plan to Resolve: Staff will follow all of [client #3's] plans for care</p>		<p>happening. We can implement a goal to teach her not to pull out the gtube but this would be contraindicated as discussion about such action leads to her pulling out her tube. Res. #3 is alert and oriented x3. She likes the attention the tube pulling causes including the trip to the ER. The facility feels as if the current plan is the most effective way to try to prevent future occurrences, and it has been successful for the past five months.</p>				

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	<p>of the G-tube site; also observations of her actions and intentions. Her psychiatrist was notified today of her frequent SIB (self-injurious behavior) this month of August. She prescribed .5 mg (milligrams) of Ativan (anti-anxiety medication) 2 times/day. The Human Rights Committee has been informed and is in the process of giving their approval of Ativan for [client #3]."</p> <p>4. "Name: [Client #3], Date: 08/22/2013, Narrative: [Client #3] was on her computer when the [facility computer repair person] came to look at her computer to get the serial number. That action seemed to set [client #3] into a tantrum. She escalated into grabbing and throwing the computer and attempting to hit staff. [Client #3] was asked chose (sic) a comfortable place in the room to relax. She chose a recliner and relaxed momentarily but began to emotionally escalate, breaking and throwing her glasses, sobbing and swiftly moving her hands under her shirt, pulling the G-tube out.... . Plan to Resolve: There is no follow up needed. The team will be trying a g-tube belt that will cover the g-tube site in a protective pocket. SGL staff will continue following the behavior plan."</p> <p>5. "Name: [Client #3], Date:</p>				

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	<p>08/19/2013, Narrative: [Client #3] became upset this AM (morning) when she attempted to get on her computer prior to breakfast. The staff were redirecting [client #3] to other options when she grabbed a hold of her G-tube button and pulled it out before staff could intervene. The behavior of pulling out her g-tube when she does not get her way is addressed in her behavior plan. Plan to Resolve: The [facility computer repair department] was able to fix the computer that [client #3] uses and is now in the house for her use. SGL staff will continue to follow her behavior plan as written."</p> <p>6. "Name: [Client #3], Date: 08/04/2013, Narrative: [Client #3] pulled her G-tube out. Within 15 minutes she was taken to the ER for a replacement tube insertion. That procedure was done without complication and [client #3] discharged without further orders. [Client #3's] computer had a virus for a couple of days and was therefore not doing what she wanted it to do. She had pushed at and tipped over the monitor a couple of times so was asked by staff to leave the computer area to get herself under control. [Client #3] sat in the living room with staff, watching TV together. While sitting indian style (legs crossed),</p>						

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	<p>as is her habit, on the couch with her hands in front of her and with her slight-of-hand act (moving her hands so staff couldn't see) she pulled the G-tube out. [Client #3] said she was mad because she couldn't be on the computer.... . Plan to Resolve: [Client #3] has an observation schedule in which her activities are checked every 5 minutes. Staff will be in-serviced to have their eyes on her constantly at times that she is angry."</p> <p>Further review on 2/17/14 at 10:37 A.M. of the aforementioned six incident reports failed to indicate the facility implemented individual "plans to resolve" which were effective in deterring client #3 from pulling out her G-tube.</p> <p>Client #3's records were reviewed on 2/21/14 at 9:54 A.M. A review of the client's Behavior Management Plan, dated 4/22/13, indicated and addressed client #3's self-injurious behavior defined as pulling out her G-tube. Further review failed to indicate the plan had been modified or updated after the original implementation date of 4/22/13 to effectively address client #3's continued behavior of pulling out her G-tube.</p>						

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	<p>The facility's records were reviewed on 2/21/14 at 10:07 A.M. The review indicated the facility had held training sessions for day program and group home staff on 5/9/13 and on 8/5/13. Further review of training records failed to indicate any training of staff after 8/5/13 to address client #3's continued behavior of pulling out her G-tube.</p> <p>Program Director #1 was interviewed on 2/21/14 at 10:22 A.M. Program Director #1 stated, "[Client #3] has always had a problem of pulling out her G-tube. It's cyclical and correlated to her computer not working."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 2/21/14 at 10:27 A.M. QIDP #1 stated, "We had training for day program staff and group home staff. The IDT (Inter-Disciplinary Team) has recently talked to [client #3's] Dad. It (client #3 pulling out her G-tube) has always been a problem."</p> <p>The facility's records were further reviewed on 2/21/14 at 2:58 P.M.. Review of the facility's Abuse/Neglect policy, dated 12/21/11, defined neglect as follows: "a. failure to provide appropriate supervision, care or training."</p>						

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W000157	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed, for 6 of 6 reviewed incidents, to implement effective corrective action to protect 1 of 4 sampled clients (client #3) from pulling out her G-tube (gastric tube) while at the facility owned day program and the group home.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/17/14 at 9:13 A.M.. The review indicated the following incidents of client #3 pulling out her G-tube.</p> <p>1. "Name: [Client #3], Date: 10/01/2013, Narrative: [Client #3] pulled her G-tube out at day program. 2) no feeding in process, 3) grabbed out by self at the end of vocational hour AFTER announcing to staff at 10:45am that she wanted to go home.... . Plan to Resolve: [Client #3] will see</p>	W000157	<p>On 3/7/14 the QIDP will be trained on interventions required in order to prevent client #3 from pulling out her g-tube. Focus of the training will be ensuring that all staff at home and day program are following the same plan. As far as interventions, the facility implemented techniques that would slow client #3 down when she is upset and wanting to pull her g-tube out. As per her behavior support plan, this is an attention seeking behavior. The team discussed further measures other than the abdominal binder and found them to fall within the category of restraint of which the facility could not implement. Client #3 is very quick and even with the binder on is able to pull her tube out. Resident #3 expresses no pain when this occurs. In the future, if staff observe any triggers that cause client #3 to pull her tube out, all staff in the house and at day program will be notified and a staffing plan put into place that will increase staff physical</p>	03/07/2014			

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	<p>Gastroenterologist as soon as possible for recommendations; will see Psychiatrist as soon as possible for recommendations; will be returned to day program following any G-tube related ER visit and will earn daily, 10 min (minutes) of 1 on 1 time (one staff with client #3) with SGL (Supervised Group Living) staff if she has not pulled the G-tube out at day program."</p> <p>2. "Name: [Client #3], Date: 09/24/2013, Narrative: [Client #3] was in her 1) base room at day services, 2) not in the feeding process, and was 3) on her computer. The usual staff in the room were keeping an eye on [client #3] while assisting other clients with a vocational activity. [Client #3] is usually content at her computer and able to focus as opposed to her mind and body wandering. One of the DSPs (Day Services Professional) saw something fly across the room from [client #3's] direction-- it was the G-tube that she had pulled out. SGL staff were notified immediately, [client #3] was taken to ER at [local hospital] and a new tube inserted by the ER physician. There were no further orders from the physician.... . Plan to Resolve: [Client #3's] BSP (Behavior Support Plan) includes self-injurious behavior and the plan is being followed. [Client #3] did</p>		<p>presence during these times in order to prevent her from pulling the tube out. If there is an issue of incidents for any individual in the home, the risk management team will review to prevent future occurrences. Staff will watch client #3 closely on a daily basis looking for triggers. The QIDP will retrain all staff that work with client #3 on her BSP. Person Responsible: QIDPADDENDUM: The abdominal binder can only be worn one way and that is wrapping across her stomach covering the gtube and Velcro in the back. Client #3 will reach over and under to pull her tube out when she wants to. As noted above, when we notice triggers, staff will be increased to the level of 1:1 to try to prevent this from happening. We can implement a goal to teach her not to pull out the gtube but this would be contraindicated as discussion about such action leads to her pulling out her tube. Res. #3 is alert and oriented x3. She likes the attention the tube pulling causes including the trip to the ER. The facility feels as if the current plan is the most effective way to try to prevent future occurrences, and it has been successful for the past five months.</p>				

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	<p>have her binder on (elastic band that covers and hinders client #3's access to her G-tube), though it does not prevent her from pulling tube out. New plans to prevent future incidents will be sent via a follow-up to this report."</p> <p>3. "Name: [Client #3], Date: 8/29/2013, Narrative: [Client #3] Stood up in her day program room and promptly pulled out her G-tube. SGL staff was called and took [client #3] to ER where a new tube was inserted. She was discharged from ER back to SGL. [Client #3] was wearing an abdominal binder at the time she pulled the tube today. Plan to Resolve: Staff will follow all of [client #3's] plans for care of the G-tube site; also observations of her actions and intentions. Her psychiatrist was notified today of her frequent SIB (self-injurious behavior) this month of August. She prescribed .5 mg (milligrams) of Ativan (anti-anxiety medication) 2 times/day. The Human Rights Committee has been informed and is in the process of giving their approval of Ativan for [client #3]."</p> <p>4. "Name: [Client #3], Date: 08/22/2013, Narrative: [Client #3] was on her computer when the [facility computer repair person] came to look at her computer to get the serial number.</p>						

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	<p>That action seemed to set [client #3] into a tantrum. She escalated into grabbing and throwing the computer and attempting to hit staff. [Client #3] was asked to chose (sic) a comfortable place in the room to relax. She chose a recliner and relaxed momentarily but began to emotionally escalate, breaking and throwing her glasses, sobbing and swiftly moving her hands under her shirt, pulling the G-tube out.... . Plan to Resolve: There is no follow up needed. The team will be trying a g-tube belt that will cover the g-tube site in a protective pocket. SGL staff will continue following the behavior plan."</p> <p>5. "Name: [Client #3], Date: 08/19/2013, Narrative: [Client #3] became upset this AM (morning) when she attempted to get on her computer prior to breakfast. The staff were redirecting [client #3] to other options when she grabbed a hold of her G-tube button and pulled it out before staff could intervene. The behavior of pulling out her g-tube when she does not get her way is addressed in her behavior plan. Plan to Resolve: The [facility computer repair department] was able to fix the computer that [client #3] uses and is now in the house for her use. SGL staff will continue to follow her behavior plan as written."</p>				

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	<p>6. "Name: [Client #3], Date: 08/04/2013, Narrative: [Client #3] pulled her G-tube out. Within 15 minutes she was taken to the ER for a replacement tube insertion. That procedure was done without complication and [client #3] discharged without further orders. [Client #3's] computer had a virus for a couple of days and was therefore not doing what she wanted it to do. She had pushed at and tipped over the monitor a couple of times so was asked by staff to leave the computer area to get herself under control. [Client #3] sat in the living room with staff, watching TV together. While sitting indian style (legs crossed), as is her habit, on the couch with her hands in front of her and with her slight-of-hand act (moving her hands so staff couldn't see) she pulled the G-tube out. [Client #3] said she was mad because she couldn't be on the computer.... . Plan to Resolve: [Client #3] has an observation schedule in which her activities are checked every 5 minutes. Staff will be in-serviced to have their eyes on her constantly at times that she is angry."</p> <p>Further review on 2/17/14 at 10:37 A.M. of the aforementioned six incident reports failed to indicate the facility</p>						

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	<p>implemented individual "plans to resolve" which were effective in deterring client #3 from pulling out her G-tube.</p> <p>Client #3's records were reviewed on 2/21/14 at 9:54 A.M. A review of the client's Behavior Management Plan, dated 4/22/13, indicated and addressed client #3's self-injurious behavior defined as pulling out her G-tube. Further review failed to indicate the plan had been modified or updated after the original implementation date of 4/22/13 to effectively address client #3's continued behavior of pulling out her G-tube.</p> <p>The facility's records were reviewed on 2/21/14 at 10:07 A.M. The review indicated the facility had held training sessions for day program and group home staff on 5/9/13 and on 8/5/13. Further review of training records failed to indicate any training of staff after 8/5/13 to address client #3's continued behavior of pulling out her G-tube.</p> <p>Program Director #1 was interviewed on 2/21/14 at 10:22 A.M. Program Director #1 stated, "[Client #3] has always had a problem of pulling out her G-tube. It's cyclical and correlated to her computer not working."</p>						

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 02/21/2014
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NAME OF PROVIDER OR SUPPLIER ADEC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 403 HAWTHORNE AVE GOSHEN, IN 46526
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(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>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 2/21/14 at 10:27 A.M. QIDP #1 stated, "We had training for day program staff and group home staff. The IDT (Inter-Disciplinary Team) has recently talked to [client #3's] Dad. It (client #3 pulling out her G-tube) has always been a problem."</p> <p>9-3-2(a)</p>			