STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G597		03/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEC INC	62836 PLANEVILLE AVE GOSHEN, IN 46526

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W 0000 Bldg. 00	This visit was for a recertification and state licensure survey. Survey Dates: 3/1, 3/2 and 3/4/16. Facility Number: 001111 Provider Number: 15G597 AIM Number: 100245600 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/10/16.	W 0000		
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 3 allegations of abuse/neglect reviewed, the facility failed to implement its recommended corrective actions involving an allegation of staff to client abuse for client #1. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 3/1/16 at 10:30 AM. The facility's 1/8/16 reportable incident report indicated "It	W 0157	All day service staff were trained on the agency A/N/E policy and reporting requirements They revieded the importance of reporting all suspected incidents so that they may be investigated immediately, and the staff removed from the facility On 1/15/16 the staff involved in squirting the gun was terminated The manager of the facility was trained on always identifying and reporting A/N/E and she was issued disciplinary action for not following policy The air horn has been removed from the facility All	03/04/2016

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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	was reported that a leadership staff woke up a client (client #1) during day program, by squirting him in the face with a squirt gun...Based on all of the information reviewed for the investigation, the evidence supports that though the use of the squirt guns was careless & (and) inappropriate, malicious intent to harm was not present and therefore the allegation does not rise to the level of an emotional/verbal abuse substantiation. Additionally, the evidence supports that the staff member thought they were all having fun together and appeared to be unaware that the client was bothered in anyway. When informed the client was bothered, she appeared remorseful and became tearful. Staff member also acknowledges that though she did not look at the bigger picture (sic) she now understands the issue present regarding possible client feelings and or responses, as well as maintaining appropriate boundaries to ensure a professional environment is provided at all times...." The 1/8/16 reportable incident report indicated "...Long Term: 1. Unless it is an isolated event, such as a squirt gun competition/game, where clients have the choice of participating or not, the squirt guns are to be removed from the day program and never to be used as a tool to wake a client up. 2.		staff were trained 1/18/16 on the difference between having fun and being abusive The staff were trained on having a respectful relationship with those we serve The staff were trained on the appropriate way to gently wake a sleeping individual Staff have been trained on being honest with those we serve, and not using them as a part of a joke In an effort to prevent this in the future, the manager of the facility and director will be sure that any abuse is reported timely and that they are present daily to make sure that no further issues will take place The manager works within the open concept day program M-F and will be aware of any further incidents Failure to comply will result in further disciplinary action Person Responsible- Manager, Director	

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	Follow-up/Disciplinary Action/Training should be taken with all staff, management included, for this specific location to address what is an appropriate way to wake up a client. Additionally, deceiving a client to believe the ceiling is leaking when he is in fact being woken up with a squirt gun should also be addressed with all staff so that each have an understanding of what is appropriate to ensure this level of disrespect is not present in the future. 3. It was identified there is an air horn at the location that clients can reach. Staff was advised that if the air horn is purposed for fire drills, it should only be used for fire drills & also moved to a location that only management have access. Additional Information: Staff did not report the incident to Human Rights according to policy; therefore procedures and policy were reviewed with staff." Interview with the Director and the Qualified Intellectual Disabilities Professional (QIDP) on 3/2/16 at 2:40 PM indicated the day programming staff should have done the training. The Director and the QIDP indicated they would find out when the training was completed. The Director indicated she was not able to obtain any additional information in regard to the alleged staff (staff #7) being retrained, and/or in			

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	regard to all facility staff being retrained on how to wake the client, and/in regard to reporting. 9-3-2(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to encourage clients to wash their hands prior to snacks/meals to prevent potential spread of infection. Findings include: During the 3/1/16 observation period between 3:20 PM and 6:05 PM at the group home, facility staff #1, #2, #3 and/or #4 did not encourage clients #1, #2, #3, #4, #5, #6, #7 and #8 to wash their hands prior to eating their dinner meal and/or prior to their evening snack (yogurt) when they came home from work and/or the day program. During the 3/2/16 observation period between 6:12 AM and 7:45 AM at the group home, client #6 was prompted 2	W 0455	All staff have been trained on the importance of hand washing, and prompting those we serve to wash hands prior to meals, after using the restroom and after coughing/sneezing Infection control practices have been reviewed Staff reviewed client #4's hand washing goal. In order to prevent this deficient practice staff will be formally monitored two times per week by the manager or QIDP to make sure hand washing is taking place or that persons served are being offered hand sanitizer and a cleansing option. The manager/QIDP will turn the monitoring documentation in to the Director on a weekly basis. The QIDP will also monitor for hand washing while working direct service shifts within the home Failure to comply will result in disciplinary action Person responsible: QID, QIDP	03/18/2016

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	different times to wash his hands after touching the lid on the kitchen garbage can. At 6:35 AM, after washing his hands the second time, client #8 walked down the hallway and sneezed into his hands. Staff #5, who was behind the client, did not prompt and/or encourage client #8 to wash his hands. At 7:00 AM, client #2 was sitting at the dining room table eating his breakfast. Client #2 sneezed into his food and then took his hand and wiped his hand across his nose/face. Staff #6, who was sitting next to the client, prompted client #2 to pass the muffins. Staff #6 then signed thank you to client #2, but did not encourage client #2 to wash his hands and/or use a hand sanitizer after the client sneezed. At 7:15 AM, client #2 sneezed and again wiped his nose with his hand and wiped his hands on his pants. Staff #6 did not encourage/assist client #2 to go to the bathroom to wash his hands and/or offer the client hand sanitizer to use to clean his hands. Client #4's record was reviewed on 3/2/16 at 1:57 PM. Client #4's 1/15/16 Individual Support Plan (ISP) indicated the client had an objective to wash his hands before he ate. Interview with the Director and the Qualified Intellectual Disabilities			

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	Professional (QIDP) on 3/2/16 at 2:40 PM indicated facility staff should encourage clients to wash their hands before meals and medication passes. 9-3-7(a)			
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure clients who had skills participated in all aspects of the snack and meal preparation. Findings include: During the 3/1/16 observation period between 3:20 PM and 6:05 PM at the group home, food (baked chicken strips) and baked potatoes were done and covered in the oven before clients #1, #2, #3, #4, #5, #6, #7 and #8 arrived to the group home at 3:40 PM. A large covered pot of carrots was sitting on top of the stove and a small pot of carrots was sitting on a second burner on top of the stove. Once the clients arrived home,	W 0488	All facility staff have been trained on the importance of active treatment and including the individuals we serve in meal and snack preparation At no times will staff prepare an entire meal for the individuals served without their participation so that they may acquire these fundamental skills Staff reviewed client #3's goal to serve himself a snack The meals and snacks will be monitored by the QIDP and manager three times per week to ensure that the deficient practice will be resolved The monitoring forms will be turned in to the director weekly Failure to comply with this correction will result in disciplinary action Persons responsible: QIDP/Res manager	03/18/2016

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	staff #2 prompted the clients to come into the dining room table to have their snack. Staff #2 verbally asked each client if they wanted strawberry or banana yogurt. Staff #2 then proceeded to serve each client their choice of yogurt into a bowl, and set the bowls in front of clients #1, #2, #3, #4, #5, #6, #7 and #8 as they sat waiting. Staff #2 did not encourage each client to serve themselves and/or to get their bowl and/or spoon. Staff #2 handed each client a spoon when he gave them their bowl of yogurt. During the above mentioned observation period, staff #3 had client #4 turn on the burners of the stove to cook the carrots which were already sitting on the stove. Staff #3 had clients #4 and #7 place rolls onto a cookie sheet and to place mandarin oranges into a serving bowl. Client #3 set the table without assistance from staff. Client #4 attempted to pick up the meat platter and potatoes to carry to the table. Staff #4 took the items from client #4 and told client #4 he (staff #4) would take the items to the table. Client #4 went and sat down at the dining room table. Client #3's record was reviewed on 3/2/16 at 1:33 PM. Client #3's 2/4/16 Individual Support Plan (ISP) indicated client #3 had an objective to serve appropriate amounts of food at mealtime			

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	(snack). Interview with client #7 on 3/1/16 at 4:34 PM indicated facility staff had cooked the dinner meal. Interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Director on 3/2/16 at 2:40 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 were capable of fixing their own snack. The QIDP and the Director indicated facility staff should involve clients in cooking all aspects of the meal/food. 9-3-8(a)			