STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G297	A. BUILDING 00 B. WING	02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADEC INC	1823 ASHLEY CT GOSHEN, IN 46526

(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
W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. This visit was in conjunction with the investigation of complaint #IN00326587. Dates of survey: 2/8, 2/9, 2/10, 2/11, and 2/12/2021. Provider Number: 15G297 AIM Number: 100243710 Facility Number: 000816 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 2/23/21.	W 0000		
W 0149 Bldg. 00	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, for 4 of 5 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect, and/or mistreatment reviewed (clients A, B, D, and E), the facility failed to implement the agency's abuse, neglect, and/or mistreatment policy and procedure to prohibit abuse, neglect, and/or mistreatment and to immediately report the allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance to State Law.	W 0149	Facility staff will be re-trained on the policy for prevention on abuse/neglect/exploitation. They will be trained on the requirement to report any suspected abuse/neglect/exploitation within 24 hours. failure to comply will result in disciplinary action. QIDP will make random weekly visits to observe for any signs of abuse/neglect/exploitation. Person responsible: QIDP	03/12/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiencystatement 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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	Findings include: On 2/8/2021 at 1:15pm and on 2/9/2021 at 9:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated the following regarding allegation of abuse, neglect, and/or mistreatment for clients A, B, D, and E: 1. A 5/1/2020 BDDS report for client B's allegation of abuse, neglect, and/or mistreatment indicated on 5/1/2020 at 7:00am client B "reported that the overnight staff knew he had soiled himself and had not changed him. Staff also alleged to have not given [client B] his medications but signed that they were given. It is unknown how long [client B] was soiled." -The 5/4/2020 "Investigative Report" indicated "It was reported that [DSP (Direct Support Professional) #11] knew [client B] was soiled and did not assist with personal care nor tell oncoming staff that [client B] was soiled. [Client B] reported this to staff." The investigation indicated DSP #11 was immediately suspended. The investigation indicated the following: The HM's (House Manager's) witness statement indicated "Received report and confirmed details. [HM] confirmed the overnight repositioning schedule was signed off that [client B] was checked on every 2 hours." DSP #11's witness statement indicated "Can you tell me about your overnight shift last night? I had questions about [client B's] oxygen (for breathing). He said he wasn't suppose to have it on, so I wasn't sure. I forgot to ask someone this morning about that. Do you do scheduled checks through the night on [client B]? Yes... Before I			

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	gave his meds. (medications) and when his food was finished (G-tube feeding). I checked on him and he was wet, so I cleaned him. What was the time? I don't remember. When you checked on him to give morning meds, what time was that? About 5:30am. Did he have a bowel movement at that time? He wasn't wet. When did you check on him again after 5:30am? It was close to 7:30am then, the next time I went in. Did you know if he had a bowel movement then? I knew he did, he told me. I was trying to give meds and the computer wasn't responding. Then another client got up and wanted breakfast. I was feeling overwhelmed. Then it was close to 8:00 and I clocked out... Do you go through verbal updates on the guys during staff changes? I usually do, but this morning I forgot... The medications for [client B] were signed as given and closed out, did you give them? Yes, I did. I gave him his meds, but I left the tube there. When he's done with his meds, I turn off the machine usually. This morning I didn't take the tube off, it was still connected... Did you give him his breathing treatment? No, I didn't have time for that. Did you sign that it was given? I don't think so." A second interview was conducted with DSP #11. DSP #11's second interview indicated "Did you give the breathing treatment? No. It was signed off that you gave it and all his meds. Did you give them? No. Did you fall asleep, because it seems like you were scrambling around to get things done? Yes, I fell asleep. I turned off [client B's] food about 3:30am and then fell asleep. I woke up about 5:30am. [Client D] was already up. That put me behind quite a bit." RN (Registered Nurse) #2's witness statement indicated "Discussed details about the med. pass, tube flushes, and breathing treatment. [RN #2] stated that with the medications and feeding,			

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	[client B's] feeding tube should have been flushed at least 3 times after his feeding. It was reported there was still food in the tube at 8:30am when day staff looked in on [client B]. Breathing treatment could not have been done as there was a new pack to be started this morning, which did not happen. Breathing treatment is scheduled to be given at 7:00am." The investigation indicated "Based on all the information reviewed for this investigation, I have determined that [client B's] incident is Substantiated. [DSP #11] admitted to falling asleep on the overnight shift. Medications were signed as given, however, with food still being in [client B's] tube, it is not possible as a flush would have occurred. [DSP #11] knew [client B] was laying (sic) in soiled bedding and declined to tell oncoming staff. Due to [DSP #11] stating she fell asleep, it is unclear how long [client B] actually laid in his soiled bedding... Recommend disciplinary action according to ADEC policy for: a. falling asleep in a 24-hour site. b. Falsification of documentation. c. Neglect. Failure to assist a client in personal care and failure to tell oncoming staff that a client was laying in soiled bedding due to his high risk for skin breakdown." 2. A 5/11/2020 BDDS report for client A indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client A]. Reporting staff state (sic) it has happened on more than once occasion. ADEC staff has been suspended pending investigation." 3. A 5/11/2020 BDDS report for client D			

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	indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client E]. Reporting staff state (sic) it has happened on more than once occasion. ADEC staff has been suspended pending investigation." 4. A 5/11/2020 BDDS report for client E indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client E]. Reporting staff state (sic) it has happened on more than once occasion. ADEC staff has been suspended pending investigation." -The 5/12/2020 "Investigative Report" indicated it was completed for clients A, D, and E's allegations of abuse, neglect, and/or mistreatment and used the same investigation to determine the results. The investigation indicated "Nature of report: Date and time (of the allegation): 4/17/2020 and 5/2/2020. Allegations include yelling at clients and provoking one particular client... [DSP #7] was immediately suspended." The investigation indicated the following: DSP #8's witness statement indicated "Can you clarify from your report who does [DSP #7] specifically yell at or target? [Clients A and D]... She doesn't like [client D]. She tends to pick on him a lot. [Client D] says that they stop by [DSP #7's] boyfriend's house a lot and she gets a drink of alcohol when they go there. This has been reported to the house manager multiple times [client D] says... Have other staff heard her yell			

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	at clients? Yes, [DSP #9 and DSP #10] have heard [DSP #7]. I have been there when she has done it in front of them. One time we were at the [name of day program] for the day and [client E] was having a hard time understanding why we had to be there. Every time [client E] calmed down, [DSP #7] would say or do something to provoke him. She would stare at him, say she was going to take his crayons or yell at him then he would have another behavior." Client D's witness statement indicated "Do staff yell at you? Mostly [DSP #7]. She drinks alcohol when her boyfriend comes to the group home. Sometimes I can smell it on the bus when she picks up up or on her breath. When she yells, what does she say? Lots of different things. How does that make you feel? Makes me feel like I did something wrong. I don't like being yelled at. She comes in at 2 and the manager comes in around 2 or 4." HR (Human Resource) #1 and HR #2's witness statement indicated "Based on [HR #1 and HR #2's] interviews with staff on another matter, it was disclosed that [DSP #7] doesn't like when (sic) [client A] talks a certain way, and she tells him that if he doesn't stop she will make him do an hour on the exercise bike without a break. [DSP #7] also states to [client A] that if he does take a break or doesn't complete the hour, [DSP #7] will increase his time by 5 minutes." DSP #9's witness statement indicated "Have you hear [DSP #7] yell at any of the guys (clients)? Oh yes, she yells at [client A], [client D] not that much. Except last week she yelled at him when he didn't want to exercise. He was very upset with her. I told him he could calm down, he would be ok." DSP #9 was interviewed a second			

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	time. "Have you ever heard a staff person tell [client A] that if he doesn't stop a particular behavior that they would make him get on the exercise bike and extend his time if he stopped? Yes. I have hear [DSP #7] tell him that and seen (sic) her do it. She says that to him when he had some pictures or when he has a different voice. Yes. I have seen her do that and I tell her that is not ok." DSP #10's witness statement indicated "Have you ever hear staff tell [client A] that if he didn't stop doing something they would make him get on the exercise bike for an hour? No." DSP #7's witness statement indicated "Can you tell me about what happened with [client D] last Friday? It wasn't Friday. It was Thursday. I reported it to [the name of house manager] on Friday. I came to work and told him hi then asked him about his exercise. He said no. I asked him to do it so he wouldn't have to do it later. He ignored me. I asked him again a few minutes later and he said no. I told him it was for his goal but he didn't have to. He said he was going to make sure I didn't drive anymore. Anytime he gets upset he tells staff he can get us in trouble. He went outside then after 4pm his friend called. I went and gave him the phone. He was happy that his friend had called. I walked away and came back a few minutes later and he was telling his friend on the phone that I go to my boyfriends to get alcohol... On 4/17/2020 the guys had to go to the [name of day program] building for the day. How was [client E] that day? I had to step in front of him a few times because I was afraid he was going to hit clients. He had hit 2 clients that day and hit all the staff. I kept telling him we were leaving soon. He was flipping tables and I eventually left the table			

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	turned over so he wouldn't do it anymore. Was he throwing items? Yes, he was throwing crayons. Did it seem to increase his agitation when you asked him to pick up the items? I finally said ok you don't have to pick them up... Do you threaten [client A] with exercise if he doesn't stop a certain behavior? No, I mean we have him exercise a bit longer if his blood sugar is high. He gets off when he wants to. The report was told to [DSP #7] at this time. Is there anything you want me to add to your statement? No, I am just a loud person." The investigation indicated "Investigation findings: Based on All the information reviewed for this investigation. I have determined that [clients A, D, and E's] incidents is (sic): Substantiated. [Client E's] incident is Substantiated for verbal abuse; causing the person to react in a negative manner... 2 staff confirmed that [DSP #7] threatens [client A] with exercise and forces him to go longer if he takes a break... [Client A's] incident is substantiated for using an aversive technique of contingent exercise... [Client A's] incident is substantiated for verbal abuse; causing the individual to experience emotional distress... Staff and client statements confirm that [DSP #7] has raised her voice to [client D]. [Client D's] incident is substantiated for verbal abuse; causing the individual to experience emotional distress... Recommend ANE (Abuse, Neglect, and Exploitation) refresher (training) for reporting staff from interviews because the staff failed to immediately report the allegations to the administrator." On 2/8/2021 at 1:35pm, an interview was conducted with the Vice President of Operations (VPO). The VPO indicated the facility followed			

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	the BDDS reporting and investigation guidelines and the facility's reporting and investigation policy and procedures to immediately report allegations of abuse, neglect, and mistreatment. The VPO indicated the agency prohibited abuse, neglect, and/or mistreatment by clients, staff, and visitors. On 2/10/2021 at 10:50am, an interview was conducted with the VPO. The VPO stated clients A, D, and E's allegations of abuse, neglect, and/or mistreatment "was substantiated staff abuse." The VPO indicated the agency took immediate action once the agency was aware of the incident and stated "the agency was not notified until after the second incident on 5/11/2020." The VPO stated the administrator was not immediately notified "of the first incident until we were investigating the second allegation." The VPO stated "that staff was wrong (for not reporting allegations immediately to the administrator and wrong when the staff mistreated clients). She doesn't work here anymore." The VPO stated "there is no question about [client B's] allegation of staff neglect. This is so sad that it even happened. Shame on the staff." The VPO indicated client B's allegation of staff to client neglect was substantiated. The VPO stated client B reported the allegation, "not the staff." The VPO indicated the facility staff failed to immediately report clients A, B, D, and E allegations of abuse, neglect, and/or mistreatment immediately to the administrator and in accordance with State Law. On 2/8/2021 at 1:35pm, the facility's 5/14/2019 "Incident Reporting and Management Policy" was reviewed. The policy indicated "ADEC Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or			

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	exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be immediately reported and thoroughly investigated as outlined in this policy...." On 2/8/2021 at 1:35pm, the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "... Abuse, Neglect, and Mistreatment of Individuals... it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff... Other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "... Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." 9-3-2(a)			
W 0153 Bldg. 00	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, for 3 of 5 BDDS (Bureau of Developmental Disabilities Services) reports regarding allegations of abuse, neglect, and/or mistreatment reviewed (clients A, D, and E), the facility failed to immediately	W 0153	Facility staff will be re-trained on the policy for prevention on abuse/neglect/exploitation. They will be trained on the requirement to report any suspected	03/12/2021

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	report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance to State Law. Findings include: On 2/8/2021 at 1:15pm and on 2/9/2021 at 9:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated the following regarding allegation of abuse, neglect, and/or mistreatment for clients A, D, and E: 1. A 5/11/2020 BDDS report for client A indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client A]. Reporting staff state it has happened on more than once occasion. ADEC staff has been suspended pending investigation." 2. A 5/11/2020 BDDS report for client D indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client E]. Reporting staff state it has happened on more than once occasion. ADEC staff has been suspended pending investigation." 3. A 5/11/2020 BDDS report for client E indicated on 5/2/2020 at 3:00pm "Date of Knowledge: 5/11/2020." The report indicated "It was reported to the ADEC Protective Services on 5/11/2020 that on 5/2/20, an ADEC DSP (Direct Support Professional) yelled at [client E]. Reporting staff state it has happened on more		abuse/neglect/exploitation within 24 hours. failure to comply will result in disciplinary action. QIDP will make random weekly visits to observe for any signs of abuse/neglect/exploitation. Person responsible: QIDP	

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	than once occasion. ADEC staff has been suspended pending investigation." -The 5/12/2020 "Investigative Report" indicated it was completed for clients A, D, and E's allegations of abuse, neglect, and/or mistreatment and used the same investigation to determine the results. The investigation indicated "Nature of report: Date and time (of the allegation): 4/17/2020 and 5/2/2020. Allegations include yelling at clients and provoking one particular client...[DSP #7] was immediately suspended." The investigation indicated the following: The investigation indicated "Investigation findings: Based on All the information reviewed for this investigation. I have determined that [clients A, D, and E's] incidents is: Substantiated. [Client E's] incident is Substantiated for verbal abuse; causing the person to react in a negative manner... 2 staff confirmed that [DSP #7] threatens [client A] with exercise and forces him to go longer if he takes a break... [Client A's] incident is substantiated for using an aversive technique of contingent exercise... [Client A's] incident is substantiated for verbal abuse; causing the individual to experience emotional distress... Staff and client statements confirm that [DSP #7] has raised her voice to [client D]. [Client D's] incident is substantiated for verbal abuse; causing the individual to experience emotional distress... Recommend ANE (Abuse, Neglect, and Exploitation) refresher for reporting staff" from interviews because the staff failed to immediately report the allegations to the administrator. On 2/8/2021 at 1:35pm, an interview was conducted with the Vice President of Operations			

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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
	(VPO). The VPO indicated the facility followed the BDDS reporting and investigation guidelines to immediately report allegations of abuse, neglect, and mistreatment. On 2/10/2021 at 10:50am, an interview was conducted with the VPO. The VPO stated clients A, D, and E's allegations of abuse, neglect, and/or mistreatment were "not immediately reported to the administrator and to BDDS. The VPO stated clients A, D, and E's allegations were "substantiated staff abuse." The VPO indicated the agency took immediate action once the agency was aware of the incidents and stated "the agency was not notified until after the second incident on 5/11/2020." The VPO stated the administrator was not immediately notified "of the first incident until we were investigating the second allegation." The VPO indicated the facility failed to report clients A, D, and E's allegations of abuse, neglect, and/or mistreatment immediately to the administrator and within 24 hours to BDDS in accordance with State Law. 9-3-2(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview for 1 of 3 sampled clients (client B), the facility failed to ensure the staff were trained by the medical professional in administering medications via client B's G-Tube (Gastrostomy Tube, a tube inserted into the stomach for nutrition).	W 0192	All PCP's of individuals with G/J tubes were contacted and scripts were received to clarify the orders regarding G/J tube care. Health Care Support Plans have been updated. Nursing staff are completing trainings for all staff that care for someone with a G/J	03/12/2021

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	15G297	A. BUILDING 00 B. WING	02/12/2021

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	Findings include: On 2/10/2021 at 7:02am, medication observation and interview were conducted at the group home with client B and DSP (Direct Support Professional) #3. At 7:02am, DSP #3 assisted client B to move his wheelchair into the medication room. DSP #3 attached tubing to client B's mickey button (opening to the G-tube) and the opposite end of the tube to an asepto syringe (a large plastic syringe with a small tip to connect to a small opening such as a tube). DSP #3 punched out each medication and crushed them in separate cups mixing each with 10 cc (cubic centimeters) of water. DSP #3 did not check for residuals (stomach contents) and did not check for placement of client D's G-tube before administering client B's medications. At 7:02am, DSP #3 started to pour each cup of medication in via the tube attached to client D's mickey button and between each medication poured 30 cc of water into the tube. DSP #3 stated client B received "at least" 30cc of water to flush his G-Tube after the final medication was administered. DSP #3 stated client B "has a new kind of G-tube and you don't have to check for placement anymore or residuals." DSP #3 stated he was trained by a previous QIDP (Qualified Intellectual Disabilities Professional) "years ago" and indicated he had not been trained by a medical professional to administer client B's feeding system and medications using his G-tube. Client B's record was reviewed on 2/10/2021 at 12:10pm. Client B's 1/21/2021 physician's order indicated "Give 200 ml (milliliters) flush via J-Tube at 7:00am, 10:00am, 2:00pm, and 5:00pm." Client B's 11/20/2020 "Health Care Support Plan" indicated "2. See Choking		tube. Training on updated health care support plans will also take place. QIDP will ensure that all new staff assigned to the home will receive training from a nurse on G/J tubes. Person responsible: Director of nursing, QIDP	

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	Management Plan. Has a Peg-tube... 9. Diet order-NPO (nothing by mouth). Has Jejunostomy tube feeding for all hydration and nutrition" and signed by the Registered Nurse (RN). Client B's 7/2020 "Choking/Swallowing Management Plan" indicated client B "is at risk of choking due to a diagnosis of Dysphagia/aspiration. Choking plan... 6. All staff will be trained on ADEC's g/j-tube protocol during new staff orientation...." On 2/11/2021 at 9:05am, the agency's undated "G-Tube Medication Administration" training and procedure was reviewed. The undated "G-Tube Medication Administration" procedure indicated "Instructions... 5. Check placement of G-tube with 10ml (milliliters) of air. 6. Then remove syringe from tube and remove plunger from syringe. 7. Replace syringe to the tube." -The undated "G-Tube, Tube Feedings and Medication pass" procedure indicated "Always check placement of the tube before passing any fluids or medications. Checking Placement using air bolus: Procedure for Air Bolus. Gather equipment, you will need a stethoscope, large bore syringe, 35-60ml without needle, and a towel. Check the location of the feeding tube by: use the syringe to quickly insert 3-5cc of air into the tube while listening with the stethoscope for a pop. The pop represents air rushing into the stomach. The feeding/medication pass should not be started if the air sound is not heard. The tube may not be in the stomach and the individual will need to be seen by the PCP (Primary Care Physician) or at the Hospital ER (Emergency Room)... Checking for Residuals. Not every client will need residuals checked... Residual is			

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	checked by connecting the large syringe 35ml or 60ml without needle to the G-Tube port. Aspirate stomach contents slowly. If greater than 100cc, return aspirant and wait 30 minutes before rechecking residual... If less than 100cc, return aspirant and start feeding. If no aspirate check placement by listening for an air bolus." On 2/10/2021 at 9:35am, Direct Support Professional (DSP) #1, DSP #2, DSP #3, and DSP #4's personnel files were reviewed and did not include training completed with the nurse/medical professional regarding G-tube care, feeding procedures, and medication administration. On 2/10/2021 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the VPO (Vice President of Operations). The VPO stated "We overlooked that training. I don't know how it happened, but it did. Staff who administer medications and tube feedings should absolutely be trained by our nurse before the staff are allowed to do this (administer medications and feedings by G-tube) on their own. There is no documented training for [DSP #3] in his personnel records." The QIDP indicated she had not provided training on G-tube feeding and medication administration. On 2/11/2021 at 9:05am, an interview with the RN (Registered Nurse) was conducted. The RN stated "All staff must be trained by the nurse before administering medications and feedings." The RN indicated she was unable to locate completed competency training for the Direct Support Professionals who worked at the group home where client B lived. The RN stated DSP #3 "had no completed G-tube training			

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	completed." The RN stated she was "unsure if" client B's physician wanted his tube checked for residuals. The RN stated "Staff should check for placement of the G-tube" before any medications and feeding is done. The RN stated "It's our policy. It's in our training I provide to new employees." 9-3-3(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 of 3 sampled clients (client B), the facility failed to ensure nursing services provided administrative oversight to monitor and ensure staff were trained by the nurse/medical professional regarding client B's G-Tube (Gastrostomy Tube, a tube inserted into the stomach for nutrition). Findings include: On 2/10/2021 at 7:02am, medication observation and interview were conducted at the group home with client B and DSP (Direct Support Professional) #3. At 7:02am, DSP #3 assisted client B to move his wheelchair into the medication room. DSP #3 attached tubing to client B's mickey button (opening to the G-tube) and the opposite end of the tube to an asepto syringe (a large plastic syringe with a small tip to connect to a small opening such as a tube). DSP #3 punched out each medication and crushed them in separate cups mixing each with 10 cc (cubic centimeters) of water. DSP #3 did not check for residuals (stomach contents) and did not check for placement of client D's G-tube	W 0331	All PCP's of individuals with G/J tubes were contacted and scripts were received to clarify the orders regarding G/J tube care. Health Care Support Plans have been updated. Nursing staff are completing trainings for all staff that care for someone with a G/J tube. Training on updated health care support plans will also take place. QIDP will ensure that all new staff assigned to the home will receive training from a nurse on G/J tubes. Person responsible: Director of nursing, QIDP	03/12/2021

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	before administering client B's medications. At 7:02am, DSP #3 started to pour each cup of medication in via the tube attached to client D's mickey button and between each medication poured 30 cc of water into the tube. DSP #3 stated client B received "at least" 30cc of water to flush his G-Tube after the final medication was administered. DSP #3 stated client B "has a new kind of G-tube and you don't have to check for placement anymore or residuals." DSP #3 stated he was trained by a previous QIDP (Qualified Intellectual Disabilities Professional) "years ago" and indicated he had not been trained by a medical professional to administer client B's feeding system and medications using his G-tube. Client B's record was reviewed on 2/10/2021 at 12:10pm. Client B's 1/21/2021 physician's order indicated "Give 200 ml (milliliters) flush via J-Tube at 7:00am, 10:00am, 2:00pm, and 5:00pm." Client B's 11/20/2020 "Health Care Support Plan" indicated "2. See Choking Management Plan. Has a Peg-tube." Client B's 12/2020, 9/2020, 6/2020, and 3/2020 "Nursing Quarterly Assessment" did not include a review of client B's G-tube use. Client B's 7/2020 "Choking/Swallowing Management Plan" indicated client B "is at risk of choking due to a diagnosis of Dysphagia/aspiration. Choking plan... 6. All staff will be trained on ADEC's g/j-tube protocol during new staff orientation...." On 2/11/2021 at 9:05am, the agency's undated "G-Tube Medication Administration" training and procedure was reviewed. The undated "G-Tube Medication Administration" procedure indicated "Instructions... 5. Check placement of G-tube with 10ml (milliliters) of air."			

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	-The undated "G-Tube, Tube Feedings and Medication pass" procedure indicated "Always check placement of the tube before passing any fluids or medications. Checking Placement using air bolus: Procedure for Air Bolus. Gather equipment, you will need a stethoscope, large bore syringe, 35-60ml without needle, and a towel. Check the location of the feeding tube by: use the syringe to quickly insert 3-5cc of air into the tube while listening with the stethoscope for a pop. The pop represents air rushing into the stomach. The feeding/medication pass should not be started if the air sound is not heard. The tube may not be in the stomach and the individual will need to be seen by the PCP (Primary Care Physician) or at the Hospital ER (Emergency Room)... Checking for Residuals. Not every client will need residuals checked... Residual is checked by connecting the large syringe 35ml or 60ml without needle to the G-Tube port. Aspirate stomach contents slowly. If greater than 100cc, return aspirant and wait 30 minutes before rechecking residual... If less than 100cc, return aspirant and start feeding. If no aspirate check placement by listening for an air bolus." On 2/10/2021 at 9:35am, Direct Support Professional (DSP) #1, DSP #2, DSP #3, and DSP #4's personnel files were reviewed and did not include training by the nurse/medical professional regarding G-tube care, feeding procedures, and medication administration. On 2/10/2021 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the VPO (Vice President of Operations). The VPO stated "We overlooked that training. I don't know how it happened, but it did. Staff who administer medications and tube feedings should absolutely			

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	be trained by our nurse before the staff are allowed to do this (administer medications and feedings by G-tube) on their own. There is no documented training for [DSP #3] in his personnel records." The QIDP indicated she had not provided training on G-tube feeding and medication administration. On 2/11/2021 at 9:05am, an interview with the RN (Registered Nurse) was conducted. The RN stated "All staff must be trained by the nurse before administering medications and feedings." The RN indicated she was unable to locate completed competency training for the Direct Support Professionals who worked at the group home where client B lived. The RN stated DSP #3 "had no completed G-tube training completed." The RN stated she was "unsure if" client B's physician wanted his tube checked for residuals. The RN stated "Staff should check for placement of the G-tube" before any medications and feeding is done. The RN stated "It's our policy. It's in our training I provide to new employees." 9-3-6(a)			
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 2 of 7 clients living in the group home (clients A and D), the facility failed to remove medication containers without labels out of the supply for clients A and D. Findings include:	W 0391	The Pharmacy was contacted and it was clarified that all individual components of a prescription need to be labeled. This will be added to the weekly medication audit to check for labeling of all medications. Staff will be trained on the added component to the	03/12/2021

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	1. On 2/9/2021 at 4:10pm, the HM (House Manager) asked client A to come to the medication room. At 4:10pm, client A with the HM selected an unlabeled Lantus 100 units Flex pen insulin for diabetes (high blood sugar), client A set the dial on the unlabeled insulin Flex pen to 27 units, and the HM attached a needle to the pen. The HM asked client A to identify where on his body he wanted the injection, the HM and client A inserted the unlabeled Flex pen into client A's skin, and both pressed the plunger to administer the insulin together. At 4:25pm, the HM indicated the Lantus Flex pen insulin did not have a pharmacy label or directions for its use, dosages, and client A's name on the medication. At 4:25pm, client A's 2/2021 E-MAR (Electronic-Medication Administration Record) indicated "Lantus Solostar pen (Flex pen), inject 27 units every evening with supper." Client A's 1/20/2021 physician's order was reviewed on 2/10/21 at 12:45pm. Client A's physician's order indicated "Lantus Solostar pen (Flex pen), inject 27 units every evening with supper." 2. On 2/10/2021 at 6:10am, DSP (Direct Support Professional) #3 asked client D to come to the medication room. At 6:10am, DSP #3 selected an unlabeled tube of Tacrolimus 0.1% ointment, applied the ointment to client D's face, and indicated the ointment was for client D's red colored rash on his facial skin. At 6:10am, DSP #3 selected an unlabeled tube (not packaged in a box with the directions) of Triple Antibiotic ointment (for skin irritation), applied the ointment to the back of client D's ears and on his neck. DSP #3 indicated the two tubes of ointments belonged to client D and neither had a pharmacy label on the ointments to indicated the		weekly medication audit. Failure to comply will result in disciplinary action. Person responsible: QIDP	

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	client's name, dosages, and directions for their use. DSP #3 indicated the facility staff followed Core A/Core B medication administration training when administering medications. DSP #3 indicated the staff should check the label on the medication to the E-MAR three times before administering to ensure the correct client, the correct dosage, and the correct directions for their use were followed. Client D's record was reviewed on 2/12/2021 at 8:45am. Client D's 1/20/2021 physician's orders indicated "Tacrolimus 0.1% ointment, apply topically (on the skin) to affected area twice daily (and) Triple Antibiotic Oint. (Ointment) 28.4, apply to affected area 1-3 times a day as needed per package instructions." On 2/11/2021 at 9:05am, an interview was conducted with the RN (Registered Nurse). The RN indicated medications should have the client's name and directions for their use on each medication. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration to ensure medications were labeled by the pharmacy. The RN indicated medications without a label should have been removed from use. The RN indicated the staff should compare the label to the E-MAR three times to ensure the correct client, the correct dosage, and the correct medication was administered to clients A and D. 9-3-6(a)			
W 0426 Bldg. 00	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility			

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	where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients A, B, and C) and for 4 additional clients (clients D, E, F, and G) to provide water below 110 degrees Fahrenheit. Findings include: On 2/9/2021 from 3:05pm until 5:30pm, an observation and interviews were conducted at the group home and clients A, C, D, E, F, G, and H accessed the three bathrooms and the kitchen sink inside the facility. During the observation period, client B sat in his wheelchair, required staff assistance to move in his wheelchair, and did not access the bathrooms and kitchen sink. At 3:15pm, the back bathroom sink had a hot water temperature of 118.8 degrees Fahrenheit. From 3:15pm until 4:30pm, clients A, D, and G showered inside the bathrooms. At 3:35pm, the House Manager (HM) took the hot water temperature with the surveyor. The hot water in the kitchen sink was 118.8 degrees Fahrenheit. The HM stated the hot water heater had been replaced "back in December, 2020. I'm sure it just needs adjusted." The HM indicated the group home was to have monitored the hot water to ensure the hot water was below 110 degrees Fahrenheit. The HM indicated no information was available for review to determine if and when the hot water temperature was monitored. At 5:05pm, the bathroom sink next to the kitchen was 118.4 degrees Fahrenheit. At 5:10pm, the back bathroom tub/shower water temperature was 118.1 degrees Fahrenheit. At 5:05pm, client A	W 0426	Facility maintenance adjusted the water temperature to below 110 degrees on 02/12/21. Facility maintenance perform monthly inspections of the water temperature to ensure the water temperature remains below 110 degrees. QIDP will check water temperature weekly to ensure that the water temperature remains below 110 degrees. If the water temperature is above 110 degrees, QIDP will contact facility maintenance immediately. Person responsible: QIDP, Facility Maintenance	03/05/2021

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	filled a glass with hot water from the kitchen sink and drank it. On 2/10/2021 at 10:50am, an interview was conducted with the VPO (Vice President of Operations). The VPO stated "In December, 2020 when the hot water heater was replaced, the maintenance department had turned off the anti-scald device and had not turned the device back on" to ensure the hot water temperature did not exceed 110 degrees Fahrenheit. The VPO stated clients A, B, C, D, E, F, and G could not mix their own water independently to ensure "the hot water remained below 110 degrees" Fahrenheit. Client A's record was reviewed on 2/10/2021 at 12:45pm. Client A's 1/19/2021 ISP (Individual Support Plan) indicated he needed an anti scald device to have the water temperature below 110 degrees. Client B's record was reviewed on 2/10/2021 at 12:10pm. Client B's 1/13/2021 ISP indicated he needed an anti scald device to have the water temperature below 110 degrees. Client C's record was reviewed on 2/10/2021 at 1:25pm. Client C's 3/9/2020 ISP indicated he needed an anti scald device to have the water temperature below 110 degrees. 9-3-7(a)			