STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G597	A. BUILDING 00 B. WING	09/15/2021

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 the investigation of complaint #IN00361478. Complaint #IN00361478: Unsubstantiated, due to lack of sufficient evidence. Unrelated deficiencies cited. Survey Dates: 9/7, 9/8, 9/9, 9/10, and 9/15/21. Facility number: 001111 Provider number: 15G597 AIM number: 100245600 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 9/29/21.	W 0000		
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 1 of 3 sampled clients (A), the facility failed to immediately report an allegation of verbal abuse and a violation of client A's rights to BDDS (Bureau of Developmental Disabilities Services) and appropriate state authorities in accordance with state law. Findings include:	W 0153	All facility staff are trained on the prevention of Abuse/Neglect/Exploitation at the time of hire. Facility staff will be retrained on the prevention of Abuse/Neglect/Exploitation. Annual training will continue for all facility staff. QIDP and/or House Manager will complete random	09/24/2021

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

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/8/21 at 3:14 PM. The review of the BDDS reports did not indicate a BDDS report had been submitted for an incident on 8/26/21. The Vice President of Residential (VPR) was interviewed on 9/9/21 at 11:00 AM. The VPR indicated client A's guardian called her on 8/27/21. The VPR stated client A's guardian reported to her "concern for [client A] being upset and angry, indicating there wasn't enough food in house." The VPR indicated client A's guardian told her "I knew [client A] was cussing, but they all p***** him off, wouldn't leave him alone and wanted to know why [client A] was upset." The VPR stated "[The Residential Manager (RM)] wanted to talk to [client A], [client A] didn't want to and [client A] was trying to pull his door shut so the [RM] would leave him alone. [Client A]'s guardian said she felt like the staff were instigating him by telling him they were going to call 911." The VPR indicated by the information she was given from the guardian she did not feel it rose to the level of a BDDS report but she did have an informal investigation completed. The VPR indicated she went to the group home the same day client A's guardian indicated the house didn't have any food and found sufficient food in the home. The VPR indicated the agency also discussed it on 8/30/21 during a weekly meeting to talk about incidents during the prior week. An undated investigation was reviewed on 9/9/21 at 11:30 AM. The undated investigation indicated "[Client A]- Regarding behavior incident on 8/26/21 at [name of group home]		observations in the home at least three times per week. They will be watching for any signs of potential abuse, neglect, or exploitation. They will be observing to ensure that all clients are being provided the care and support needed as well as observing to ensure that all clients are being treated with respect. Any suspected abuse, neglect, or exploitation will be reported immediately to protective services. Any credible allegation of abuse, neglect, or exploitation will be reported to BDDS and the appropriate state authorities. Investigations of alleged abuse, neglect, or exploitation will include all staff and clients in the home. Persons Responsible: Protective Services staff, QIDP, Director of Residential Services.	

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	See email statements from 2 staff on 8/26/21. [Name of VPR], VP, Chief Program Officer, phone conversation with [client A]'s guardian 8/27/21 8am 1.5 hours. Guardian stated [client A] told her there was no food in the house and that staff wouldn't let him out of his (room). This was immediately unsubstantiated as there is food in the home as well as a required 3-day supply. His preferred foods may not have been in the home. Doors in the group homes do not have locks on them. On 8/27/21, [the VPR] checked his lunch and (it) was adequate. Guardian complained about staff's response to [client A] about calling 911 due to his threats and aggression. Staff are trained that if they feel unsafe due to an individuals' (sic) behavior, they are to call 911. Guardian asked about his behavior plan, that she had been asking for copies, and why aren't staff doing what they are supposed to do to de-escalate the behaviors. [Client A]'s guardian feeds into his behaviors when he calls her. The previous QIDP (Qualified Intellectual Disability Professional) had attempted to involve the guardian in developing the behavior plan, however, she refused. Guardian has been notified the change in QIDP's and has never requested a copy of the plan. Interview with [client A] on 8/27/21 10:00am: [Client A] is frustrated about his upcoming move to a new provider. He wants to move right away but does not understand all the pieces need to be			

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	in place before that happens. [The VPR] encouraged him to call the contact with the new provider, who he says he calls often, and ask them how the process is going. He wanted to get out of his room and staff shut the door before he got to the door, staff felt threatened by him and that he was running after her. [Client A] stated that is not what he was doing. However, he kept yelling at staff and stating he wanted to be left alone. Staff shut the door like he requested. It has been determined this did not meet DDRS (Division of Disability and Rehabilitation Services)/BQIS (Bureau of Quality Improvement Services)/BDDS reporting guidelines since there was no abuse, neglect or exploitation. [Name of VPPS], VP Protective Services 8/27/21 2:27pm QIDP Review: [Name of QIDP] 8/27/21 [Client A] had left with his parents, was not able to interview. Discussion with house manager and staff who were present at time of incident. Discussed not approaching him when he is angry since he tends to escalate. Also discussed the manipulation and staff shouldn't internalize when he does this, it is a behavior. When they feed into it, he escalates this behavior. No revision to the BSP (Behavior Support Plan) is needed. Staff were following the BSP at the time. Some additional coaching with staff was needed. No further follow up needed. Talked with [client G] and [client B], they stated they are tired of how [client A] treats staff. Otherwise, the individuals in the home are not at risk for ANE (Abuse, Neglect, Exploitation). 4 other individuals declined to comment.			

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Director Review: [name of DOR] 08/31/21

QIDP continues to reach out to the case manager to help facilitate the move. [The VPR] talked with staff about de-escalation of aggressive behaviors."

Staff #2 was interviewed on 9/9/21 at 10:25 AM. Staff #2 indicated client A told her about an incident which happened at the group home on 8/26/21. Staff #2 indicated client A told her the RM had yelled at him and came into his room when he did not want her to. Staff #2 indicated client A came in to work before complaining about staff yelling at him and staff #2 will relay the information to the group home staff. Staff #2 indicated she did not tell administration about client A alleging staff in the group home yelled at him.

The Residential Manager was interviewed on 9/9/21 at 11:30 AM. The RM indicated on 8/26/21 staff #1 called her indicating client A was cussing at other clients in the home, was upset with staff #1, and started throwing stuff off her desk. The RM indicated she drove to the home, went to client A's door, knocked, and asked if she could come in. The RM indicated client A told her "no" but she went in and asked him why he was upset. The RM indicated client A came towards her flailing his arms and she thought he was going to hit her so she closed the door and before she could let go he tried to open it, but her hand was still on it. The RM indicated she let go of the door handle and client A was able to open the door. The RM stated "I understand how he could have misunderstood and thought I was trying to hold the door, but I wasn't. I just happened to still have my hand on the door

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	when he tried to open it. I let go of the door handle and he came out of his room." The RM indicated she probably raised her voice to talk over client A yelling, but she was not yelling at client A. The RM indicated she told client A if he tried to hit her or her staff she would have to call 911. The Director of Residential (DOR) was interviewed on 9/9/21 at 12:40 PM. The DOR indicated if an allegation of abuse, neglect, or exploitation was made staff should report it immediately. The DOR indicated if allegations are made by any person, including guardians, they should be reported and then investigated. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to thoroughly investigate an allegation of verbal abuse and a violation of client A's rights by not interviewing all staff who worked in the home and all clients who lived in the home. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/8/21 at 3:14 PM. The review of the BDDS reports did not indicate a BDDS report had been submitted for an incident on 8/26/21. The Vice President of Residential (VPR) was interviewed on 9/9/21 at 11:00 AM. The VPR indicated client A's guardian called her on	W 0154	All facility staff are trained on the prevention of Abuse/Neglect/Exploitation at the time of hire. Facility staff will be retrained on the prevention of Abuse/Neglect/Exploitation. Annual training will continue for all facility staff. QIDP and/or House Manager will complete random observations in the home at least three times per week. They will be watching for any signs of potential abuse, neglect, or exploitation. They will be observing to ensure that all clients are being provided the care and support needed as well as observing to ensure that all clients	09/24/2021

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	8/27/21. The VPR stated client A's guardian reported to her "concern for [client A] being upset and angry, indicating there wasn't enough food in house." The VPR stated client A's guardian told her "I knew [client A] was cussing, but they all p***** him off, wouldn't leave him alone and wanted to know why [client A] was upset." The VPR stated "[The Residential Manager (RM)] wanted to talk to [client A], [client A] didn't want to and [client A] was trying to pull his door shut so the [RM] would leave him alone. [Client A]'s guardian said she felt like the staff were instigating him by telling him they were going to call 911." The VPR indicated by the information she was given from the guardian she did not feel it rose to the level of a BDDS report but she did have an informal investigation completed. The VPR indicated she went to the group home the same day client A's guardian indicated the house didn't have any food and found sufficient food in the home. The VPR indicated the agency also discussed it on 8/30/21 during a weekly meeting to talk about incidents during the prior week. An undated investigation was reviewed on 9/9/21 at 11:30 AM. The undated investigation indicated "[Client A]- Regarding behavior incident on 8/26/21 at [name of group home]. See email statements from 2 staff on 8/26/21. [Name of VPR], VP, Chief Program Officer, phone conversation with [client A]'s guardian 8/27/21 8am 1.5 hours. Guardian stated [client A] told her there was no food in the house and that staff wouldn't let him out of his (room). This was immediately unsubstantiated as there is food in the home as well as a required 3-day		are being treated with respect. Any suspected abuse, neglect, or exploitation will be reported immediately to protective services. Any credible allegation of abuse, neglect, or exploitation will be reported to BDDS and the appropriate state authorities. Investigations of alleged abuse, neglect, or exploitation will include all staff and clients in the home. Persons Responsible: Protective Services staff, QIDP, Director of Residential Services.	

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	supply. His preferred foods may not have been in the home. Doors in the group homes do not have locks on them. On 8/27/21, [the VPR] checked his lunch and (it) was adequate. Guardian complained about staff's response to [client A] about calling 911 due to his threats and aggression. Staff are trained that if they feel unsafe due to an individuals' (sic) behavior, they are to call 911. Guardian asked about his behavior plan, that she had been asking for copies, and why aren't staff doing what they are supposed to do to de-escalate the behaviors. [Client A]'s guardian feeds into his behaviors when he calls her. The previous QIDP (Qualified Intellectual Disability Professional) had attempted to involve the guardian in developing the behavior plan, however, she refused. Guardian has been notified the change in QIDPs and has never requested a copy of the plan. Interview with [client A] on 8/27/21 10:00am: [Client A] is frustrated about his upcoming move to a new provider. He wants to move right away but does not understand all the pieces need to be in place before that happens. [The VPR] encouraged him to call the contact with the new provider, who he says he calls often, and ask them how the process is going. He wanted to get out of his room and staff shut the door before he got to the door, staff felt threatened by him and that he was running after her. [Client A] stated that is (sic) not what he was doing. However, he kept yelling at staff and stating he wanted to be left alone. Staff shut the door like he requested.			

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It has been determined this did not meet DDRS (Division of Disability and Rehabilitation Services)/BQIS (Bureau of Quality Improvement Services)/BDDS reporting guidelines since there was no abuse, neglect or exploitation.

[Name of VPPS], VP Protective Services
8/27/21 2:27pm
QIDP Review: [Name of QIDP] 8/27/21

[Client A] had left with his parents, was not able to interview. Discussion with house manager and staff who were present at time of incident. Discussed not approaching him when he is angry since he tends to escalate. Also discussed the manipulation and staff shouldn't internalize when he does this, it is a behavior. When they feed into it, he escalates this behavior. No revision to the BSP is needed. Staff were following the BSP at the time. Some additional coaching with staff was needed. No further follow up needed.

Talked with [client G] and [client B], they stated they are tired of how [client A] treats staff.

Otherwise, the individuals in the home are not at risk for ANE (Abuse, Neglect, Exploitation). 4 other individuals declined to comment.

Director Review: [name of DOR] 08/31/21

QIDP continues to reach out to the case manager to help facilitate the move. [The VPR] talked with staff about de-escalation of aggressive behaviors."

The Residential Manager was interviewed on 9/9/21 at 11:30 AM. The RM indicated on 8/26/21 staff #1 called her indicating client A

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	was cussing at other clients in the home and was upset with staff #1, and started throwing stuff off of her desk. The RM indicated she drove to the home, went to client A's door, knocked, and asked if she could come in. The RM indicated client A told her "no" but she went in and asked him why he was upset. The RM indicated client A came towards her flailing his arms and she thought he was going to hit her so she closed the door and before she could let go he tried to open it, but her hand was still on it. The RM indicated she let go of the door handle and client A was able to open the door. The RM stated "I understand how he could have misunderstood and thought I was trying to hold the door, but I wasn't. I just happened to still have my hand on the door when he tried to open it. I let go of the door handle and he came out of his room." The RM indicated she probably raised her voice to talk over client A yelling, but she was not yelling at client A. The RM indicated she told client A if he tried to hit her or staff she would have to call 911. The RM indicated she had not been interviewed for an investigation and only submitted an e-mail to the Vice President of Protective Services (VPPS). The Director of Residential (DOR) was interviewed on 9/9/21 at 12:40 PM. The DOR indicated all allegations of abuse, neglect, or exploitation should be thoroughly investigated by interviewing all clients and staff in the group home. 9-3-2(a)			
W 0191 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies			

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	directed toward clients' behavioral needs. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure staff was trained and competent in implementing client A's Behavior Support Plan (BSP). Findings include: The Residential Manager was interviewed on 9/9/21 at 11:30 AM. The RM indicated on 8/26/21 staff #1 was working by herself at the group home. The RM indicated staff #1 called her indicating client A was cussing at other clients in the home and had was with staff #1, and started throwing stuff off of her desk. The RM indicated she drove to the home, went to client A's door, knocked, and asked if she could come in. The RM stated client A told her "no" but she went in and asked him why he was upset. The RM indicated client A came towards her flailing his arms and she thought he was going to hit her so she closed the door and before she could let go he tried to open it, but her hand was still on it. The RM indicated she let go of the door handle and client A was able to open the door. The RM stated "I understand how he could have misunderstood and thought I was trying to hold the door, but I wasn't. I just happened to still have my hand on the door when he tried to open it. I let go of the door handle and he came out of his room." The RM indicated she probably raised her voice to talk over client A yelling, but she was not yelling at client A. The RM indicated she told client A if he tried to hit her or staff she would have to call 911. The Vice President of Residential (VPR) was interviewed on 9/9/21 at 11:00 AM. The VPR indicated client A's guardian called her on 8/27/21. The VPR stated client A's guardian	W 0191	Client A's behavior support plan was updated to include physical aggression. All staff who work with Client A were trained on his updated behavior support plan. In addition, the staff were also re-trained on MANDT positive behavioral support techniques. Client A has since moved into a CIH waiver setting at another provider. Persons Responsible: QIDP	09/24/2021

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	reported to her "concern for [client A] being upset and angry, indicating there wasn't enough food in house." The VPR stated client A's guardian told her "I knew [client A] was cussing, but they all p***** him off, wouldn't leave him alone and wanted to know why [client A] was upset." The VPR stated "[The Residential Manager (RM)] wanted to talk to [client A], [client A] didn't want to and [client A] was trying to pull his door shut so the [RM] would leave him alone. [Client A]'s guardian said she felt like the staff were instigating him by telling him they were going to call 911." The VPR indicated staff was instructed if they ever feel unsafe due to a client's physical aggression they can call 911. Client A's record was reviewed on 9/9/21 at 11:00 AM. Client A's 12/2020 BSP indicated " ...ADAPTIVE BEHAVIOR TRAINING 1. [Client A] does better when he has clear expectations. Help him to develop a clear schedule with advance notice of changes when possible. Remind him of behavioral expectations at the start of an activity. 2. Model appropriate social interactions 3. DSP (Direct Support Professional) may role play social situations where he may have to wait for gratification. 4. Give praise for appropriate social interactions. 5. Avoid using 'no' statements. Give a timeline of when a request might happen or use alternative statements. 6. Give multiple opportunities to make choices throughout the day. Avoid power struggles. MALADAPTIVE BEHAVIOR REDUCTION When [client A] engages in Verbal Aggression:			

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	yelling, swearing, blaming others for making him upset 1. Be clear what you expect of him i.e. '[Client A] I need you to stop yelling.' 2. If [client A] responds positively, give him verbal praise. 3. If [client A] continues being aggressive, ask him to go to a quiet place to calm himself. 4. If [client A] takes himself to a quiet place, give him verbal praise. 5. If [client A] continues to be aggressive, you can remove everyone else from the current environment to give [client A] time to calm himself. 6. Record the incident as verbal aggression ...". Client A's 12/2020 BSP (Behavior Support Plan) did not indicate staff should call 911 or tell client they are going to call 911. The Director of Residential (DOR) was interviewed on 9/9/21 at 12:40 PM. The DOR indicated staff should be able to competently implement client A's BSP. 9-3-3(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to include client A's behavior of physical aggression in his BSP (Behavior Support Plan). Findings include:	W 0227	Client A's behavior support plan was updated to include physical aggression. All staff who work with Client A were trained on his updated behavior support plan. In addition, the staff were also	09/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G597	A. BUILDING 00 B. WING	09/15/2021

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

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/8/21 at 3:14 PM and indicated the following: 1. A 7/14/21 BDDS report indicated " ...On 7/12/21 at 8am, this client (client A) was on the group home van being transported to the day program. ADEC staff reported this client (client A) hit another client on the back of their head ...ADEC staff immediately intervened to ensure safety. They had arrived at day program immediately after the incident, so the clients were not around each other after that. Staff addressed the incident appropriately." 2. An 8/2/21 BDDS report indicated " ...On 8/1/21 at 4:15pm, this client (client A) was at his home. ADEC staff reported they did not witness this incident, however, were in the next room and heard another client yell out. When staff went to check, this client stated he had stepped on the other client's toes ...ADEC staff immediately intervened to ensure safety. No injuries resulted from this incident. Clients were separated." Client A's record was reviewed on 9/9/21 at 11:00 AM. Client A's 12/2020 BSP did not indicate client A had a behavior of physical aggression. The Vice President of Residential (VPR) was interviewed on 9/9/21 at 11:00 AM. The VPR indicated client A had a history of being physically aggressive with staff and peers. The Residential Manager was interviewed on 9/9/21 at 11:30 AM. The RM indicated client A had a history of being physically aggressive to clients and staff in the home. The RM indicated		re-trained on MANDT positive behavioral support techniques. Client A has since moved into a CIH waiver setting at another provider. Persons Responsible: QIDP	

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	she was not aware of client A's BSP indicating he was physically aggressive and how to handle it if he was. Staff #1 was interviewed on 9/10/21 at 11:09 AM. Staff #1 indicated client A had a history of being physically aggressive. Staff #1 indicated client A had slapped another client in the back of the head and had tried to kick a refrigerator door closed while she was in it getting food put away. Staff #1 indicated client #1's BSP did not indicate he had a history of physical aggression. The Director of Residential (DOR) was interviewed on 9/9/21 at 12:40 PM. The DOR indicated client A had a history of being physically aggressive and his plan should include the behavior. The DOR indicated it would be helpful for staff to have guidance on what to do when client A is physically aggressive. 9-3-4(a)			