

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G707	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2013
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 N HILL ST SOUTH BEND, IN 46617
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: June 10, 11, 12, 14 and 24, 2013.</p> <p>Facility Number: 003833 Provider Number: 15G707 AIM Number: 200453450</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 5, 2013 by Dotty Walton, QIDP.</p>	W000000		

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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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to maintain an accurate accounting system for 2 of 4 clients living at the group home (clients #2 and #4), for whom the facility managed their personal funds accounts.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the group home on 6/10/13 at 9:16 A.M. A review of clients #2 and #4's financial records indicated the following:</p> <p>Client #2's personal financial accounting ledger dated 6/1/13 indicated he should have a balance of \$61.47. The Group Home Manager (GHM) reviewed the currency in client #2's petty cash pouch and counted a balance of \$60.43.</p> <p>Client #4's personal financial accounting ledger dated 6/1/13 indicated he should have a balance of \$7.76. The GHM reviewed the currency in client #4's petty cash pouch and counted a balance of \$66.68.</p>	W000140	The Residential Director has completed an audit of the client house account funds and their bank accounts. Client #2's account appeared to be change that was displaced into the house petty cash and for client #4, there does appear to be an error upon withdrawal at the bank. Both of these issues however should have been reported to the director immediately for review. The manager has received re-training on reporting any discrepancies to the director. The director reviews financials monthly on a routine basis but will complete an additional audit to ensure proper accounting of all client funds.	07/24/2013			

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	<p>An interview with the GHM was conducted on 6/10/13 at 9:35 A.M.. The GHM indicated each client's ledger entry balance and the currency amount should always match. The GHM further indicated client #4's balances did not match because there was a mix up with another client's finances who has a similar bank account number.</p> <p>9-3-2(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), the facility failed to ensure the clients' active treatment programs were implemented across all training environments (the facility, community outings and the facility operated day program).</p> <p>Findings include:</p> <p>An observation was conducted at the facility owned day program on 6/11/13 from 10:15 A.M. until 10:50 A.M. During the entire observation period clients #1, #2, #3 and #4 did not arrive at the facility owned day program as scheduled.</p> <p>An interview with the Day Program Manager (DPM) was conducted on 6/11/13 at 10:20 A.M. The DPM indicated clients #1, #2, #3 and #4 should have arrived at the day program at 9:00 A.M. The DPM further stated clients #1, #2, #3 and #4 "often" were not</p>	W000249	All staff have been retrained on the proper implementation of active treatment and goals and objectives identified in the ISP. The QDDP and Residential Manager will monitor active treatment on all shifts and will document that the staff have been observed providing continuous active treatment. These observations will be documented on a staff observation form and turned into the director for	07/24/2013			

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	<p>transported to the day program. The DPM further indicated clients #1, #2, #3 and #4 did not attend day programming about once a week. At 10:30 A.M., the DPM indicated the clients were not transported to the day program due to one of the clients having an appointment and further indicated they were at a park.</p> <p>An observation was conducted on 6/11/13 at a public park from 11:30 A.M. until 1:00 P.M. During the entire observation period, clients #1, #2, #3 and #4 sat with no activity. Client #1 slept the entire time. Clients #2 and #3 sat with no activity/training.</p> <p>Review (6/12/13 at 4:00 PM) of client #1's record indicated a 5/17/13 IPP (Individual Program Plan) with objectives to greet staff/others with a handshake, choose items/activities during day program, increase money skills and increase psychomotor skills by spending time out of the wheelchair. The IPP had an accompanying active treatment schedule for day program time frames of 9:45 AM until 2:15 PM which listed, in part, skills to be trained were hygiene, sensory stimulation (auditory, tactile and olfactory), and doing games/puzzles.</p> <p>A review of client #2's record was conducted on 6/12/13 at 3:20 P.M.</p>						

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	<p>Review of client #2's IPP dated 9/26/12, indicated the client was to participate with physical assistance in activities, increase participation of communication by doing dessert preparation, and increasing psychomotor skills by being out of the wheelchair to explore the client's surroundings. The IPP had an accompanying active treatment schedule for day program time frames of 9:45 AM until 2:15 PM which listed, in part, skills to be trained were hygiene, sensory stimulation (auditory, tactile and olfactory), and doing games/puzzles.</p> <p>A review of client #3's record was conducted on 6/12/13 at 4:30 P.M. Review of client #3's IPP dated 5/30/13 indicated skills to be trained were increasing understanding of money by stating an item she would like to buy, choosing an activity item, increasing ROM (Range of Motion) of upper extremities by mobilizing her wheelchair using her hands/arms. The IPP had an accompanying active treatment schedule for day program time frames of 9:45 AM until 2:15 PM which listed, in part, skills to be trained were hygiene, sensory stimulation (auditory, tactile and olfactory), and doing games/puzzles.</p> <p>A review of client #4's IPP dated 12/20/12 on 6/12/13 at 4:35 PM indicated the client</p>				

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	<p>was to be out of the wheelchair for repositioning and to explore surroundings and was to pick an activity to do during day program. The IPP had an accompanying active treatment schedule for day program time frames of 9:45 AM until 2:15 PM which listed, in part, skills to be trained were hygiene, sensory stimulation (auditory, tactile and olfactory), and doing games/puzzles.</p> <p>An interview was conducted with Group Home Trainers (GHT) #9 and #10 on 6/11/13 at 11:35 A.M. GHTs #9 and #10 indicated client #4 had an appointment at 12:45 P.M., and further indicated they did not transport the clients to the day program because of the appointment. Clients #1, #2, #3 and #4 did not leave the park until 1:00 P.M.</p> <p>An interview with the Residential Director (RD) was conducted on 6/11/13 at 11:00 A.M. The RD indicated the clients did not go to the day program due to client #4 having an appointment. The RD further indicated the staff took the clients to the park, since the weather was nice. When asked if they were scheduled to attend day program on 6/11/13, she stated "Yes." When asked if the clients had gone to the park on 6/11/13, the RD indicated they were going to the park since the weather was nice. The RD</p>						

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	indicated staff should implement active treatment objectives/activities at all times of opportunity. 9-3-4(a)				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 2 sampled clients (client #1), and 1 additional client (client #4), the facility's nursing services failed to reconcile doctor's orders with labels and Medication Administration Records (MAR).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/10/13 from 7:00 A.M. until 9:45 A.M. At 7:20 A.M., clients #1 and #2 began eating breakfast which consisted of cold cereal and toast. At 8:15 A.M., Group Home Trainer (GHT) #3 administered client #4's prescribed medications. GHT #3 administered client #4's "Divalproex 250 mg (milligram) tablet (psychosis)...1 tablet orally twice daily...Thera M Tablet (supplement)...1 tablet orally once a day." GHT #3 did not administer client #4's Divalproex 500 mg tablet. A review of the medication packet label, the 6/13 Medication Administration Record (MAR) and 6/13 Physician's Order (PO) was conducted at 8:20 A.M. The medication label indicated: "Divalproex 250 mg tablet take with 500 mg tablet</p>	W000331	All staff including the nurse have received additional training on the AWS Medication Administration Policy including checking the label and proper documentation of order changes. The staff will be monitored by the QDDP, Residential Manager and nurse to ensure compliance. Monitoring of these checks will be documented on the Medication Administration Record Tracking form which will be turned into the director to monitor compliance and ensure proper procedures are being implemented.	07/24/2013			

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	<p>(750 mg)...Thera M Tablet...1 tablet orally once a day...Take on an empty stomach." Review of the MAR indicated: "Divalproex 250 mg tablet take with 500 mg tablet (750 mg)...Thera M tablet...1 tablet orally once a day." Further review of the MAR indicated: "Divalproex 500 mg tablet...take 1 tablet orally with 250 mg tablet...D/C (discontinued)." The MAR did not indicate how client #4's prescribed medications should be administered. Client #4 did not get his Thera M tablet on an empty stomach.</p> <p>At 8:40 A.M., GHT #3 administered client #1's prescribed medications. GHT #3 administered client #1's "Thera M Tablet (supplement)...1 tablet orally once a day." A review of the medication packet label, the 6/13 Medication Administration Record (MAR) and 6/13 PO was conducted at 8:45 A.M. The medication label indicated: "Thera M Tablet...1 tablet orally once a day...Take on an empty stomach." Review of the MAR indicated: "Thera M tablet...1 tablet orally once a day." The MAR did not indicate how client #1's prescribed medications should be administered. Client #1 did not get her Thera M tablet on an empty stomach.</p> <p>An interview with the facility's Residential Director (RD) was conducted</p>				

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	on 6/14/13 at 11:30 A.M. When asked who checked the MAR, PO and medication packages to ensure the directives for administration matched, the RD stated "Our nurse does." 9-3-6(a)				

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 clients observed during the morning medication administration (client #3), to ensure staff administered 2 of 5 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/10/13 from 7:00 A.M. until 9:45 A.M. At 7:45 A.M., Group Home Trainer (GHT) #3 took an inhaler out of a clear plastic bag and administered 1 puff to client #3. GHT #3 did not shake the inhaler prior to administering. GHT #3 then retrieved a second inhaler out of another clear plastic bag and administered 2 puffs to client #3. GHT #3 did not shake the inhaler prior to administering and did not wait 1 minute between each puff.</p> <p>A review on 6/10/13 at 7:55 AM of the Medication Administration Record (MAR) dated June 1, 2013 to June 30, 2013 indicated: "Flovent 110 mcg (microgram) Inhaler (asthma)...Inhale 1</p>	W000369	All staff have been re-trained on the AWS Medication Administration Policy including the need to check the order and verify instructions prior to administration of medications. The staff will be monitored for compliance by the management team. This monitoring will be documented on the Medication Administration Observation form which will be turned into the director to monitor compliance.	07/24/2013			

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	<p>puff by mouth 2 times daily...Shake well...Pro Air 90 mcg Inhaler (asthma)...Inhale 2 puffs by mouth twice daily...Shake well before using...wait 1 minute between puffs."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:30 A.M. The RD indicated client #3's inhaler should have been shaken and GHT #3 should have waited 1 minute between puffs. The RD further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p>			

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), to ensure only authorized persons had access to the keys to the medication lock box and cabinet.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/10/13 from 7:00 A.M. until 9:45 A.M. During the entire observation, Group Home Trainers (GHT) #1, #2, #3 walked in and out of the unlocked medication room. At 6:45 A.M., GHT #3 retrieved the group home medication cabinet keys out of an unlocked drawer in the unlocked room located off of the open dining/kitchen/living area and began administering client #3's prescribed medications. At 8:01 A.M., GHT #3 placed the medication keys on top of the cabinet and left out of the room. At 8:08 A.M., GHT #3 entered back into the room, picked the medication keys up from on top of the cabinet and began administering client #2's prescribed medications. At 8:11 A.M., GHT #3 placed the medication keys on top of the cabinet and exited out of the room. At</p>	W000383	All staff have received additional training on the proper storage of medications. This training included securing the medication keys by keeping them on an authorized person. The staff will be monitored by the management team to ensure that the medication storage policy is being followed. Observations will be documented on a Medication Administration Record Tracking form which will be turned into the director to monitor compliance.	07/24/2013

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	<p>8:15 A.M., GHT #3 entered the room, picked up the medication keys and began administering client #4's prescribed medications. At 8:31 A.M., GHT #3 placed the medication keys in an unlocked drawer and exited the office. At 8:40 A.M., GHT #3 entered the unlocked room and took the medication keys out of the drawer and began administering client #1's prescribed medications. At 9:00 A.M., GHT #3 put the medication keys in a drawer in the unlocked medication room.</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:30 A.M. The RD indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p>				

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W000388	<p>483.460(m)(1)(i) DRUG LABELING</p> <p>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 clients observed during morning medication administration (client #3), to have the medication labeled.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/10/13 from 7:00 A.M. until 9:45 A.M. Client #3's medications were administered by Group Home Trainer (GHT) #1 at 7:45 A.M. A bottle was taken from client #3's medication bin. The bottle did not contain client #3's name or instructions for administration. The bottle did not contain a pharmacy label.</p> <p>A review of the Medication Administration Record dated June 1, 2013 to June 30, 2013 was conducted at 7:55 A.M. on 6/10/13. The MAR indicated: "D3 2000 (supplement)...1 tablet orally once a day."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:30 A.M. The RD indicated all medications should be labeled with each</p>	W000388	All the medications have been checked by the nurse and are labeled appropriately. All staff received additional training on the AWS Medication Administration Policy and the Medication labeling policy. The management staff will check medications for proper labeling weekly and will document on the Medication Administration Record Tracking form. This form will be turned into the director so that compliance can be monitored.	07/24/2013			

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	client's name and instructions for administration. 9-3-6(a)				

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 2 sampled clients (client #2), and 1 additional (client #3), the facility failed to assure the staff provided food in accordance with clients' diet orders.</p> <p>Findings include:</p> <p>A daytime observation was conducted on 6/11/13 from 11:30 P.M. until 1:00 P.M. At 11:30 A.M., Group Home Trainer (GHT) # 7 fed client #2 his lunch and GHT #8 fed client #3 her meal. Both meals consisted of a baby food consistency ham sandwich, pears and Cole slaw. The Cole slaw was not of a pureed consistency. The carrots and cabbage could be recognized. Clients #2 and #3's Cole slaw was not of a pureed consistency.</p> <p>A review of client #2's record was conducted on 6/12/13 at 3:20 P.M. Review of client #2's most current Nutritional Assessment dated 4/15/13 indicated: "Pureed (consistency) diet."</p> <p>A review of client #3's record was conducted on 6/12/13 at 4:30 P.M.</p>	W000460	All staff have received retraining on the preparation of modified diets and have completed return demonstrations to ensure that the training has been effective. The manager and QDDP will complete spot checks to ensure that staff have implemented their training. These checks will be documented on the Dining Skills Checklist and will be turned into the director for review and to monitor compliance.	07/24/2013			

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	<p>Review of client #3's most current Nutritional Assessment dated 12/8/12 indicated: "Pureed (consistency diet)."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:30 A.M. The RD indicated staff should have followed each client's prescribed diet.</p> <p>9-3-8(a)</p>						

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W000488	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to assure 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), were involved in meal preparation and served themselves at meal times as independently as possible.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/10/13 from 7:00 A.M. until 9:45 A.M.. Clients #1, #2, #3 and #4 sat at the dining table with no activity as Group Home Trainer (GHT) #2 took food containers out of the refrigerator and placed them on the table. The containers were labeled and indicated the meal they held consisted of cereal and toast. At 7:20 A.M., GHT #2 served each client's food into their bowls. Clients #1, #2, #3 and #4 did not assist in meal preparation or in serving themselves.</p> <p>An evening observation was conducted at the group home on 6/10/13 from 3:00 P.M. until 5:15 P.M. During the observation period, clients #1, #2, #3 and #4 sat in the living room with no activity. At 4:20 P.M., GHT #4 took several</p>	W000488	All staff received additional training on the clients ability to participate in meal preparation as determined by their assessments. Spot checks are being completed by the management staff to ensure that this training has been effective. The management staff are completing Dining Observation Checklists at various meals to document their observations, note areas of retraining if needed and these checklist are monitored by the director to ensure compliance.	07/24/2013			

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	<p>containers filled with prepared blended food out of the refrigerator and placed them into the microwave oven. The containers were labeled and indicated the meal consisted of barbequed chicken, carrots, mashed potatoes and apricots. At 4:45 P.M., DSPs #4, #5 and #6 placed each client's food onto their plates. Clients #1, #2, #3 and #4 did not assist in meal preparation or serving themselves.</p> <p>An interview with GHT #5 was conducted on 6/10/13 at 5:00 P.M. GHT #5 indicated clients did not assist in meal time preparation. GHT #5 further indicated third shift/overnight staff prepared all meals for the clients.</p> <p>A review of client #2's record was conducted on 6/12/13 at 4:45 P.M. Review of the most current Individual Support Plan (ISP) dated 9/26/12 indicated: "Will follow 1 direction from staff given hand over hand assistance during dessert preparation."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:35 A.M. The RD indicated clients were capable assisting in meal preparation and of serving themselves with assistance and further indicated they should be assisting in preparation and serving themselves with assistance at meal time.</p>			

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