

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/25/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614		
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: May 23, 24 and 25, 2012.</p> <p>Facility Number: 003799 Provider Number: 15G705 AIMS Number: 200447350</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/6/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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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W0249	<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, the facility failed for 1 of 2 sampled clients (client #1) who had Dysphagia Care Plan/Mealtime Guidelines which included a dining objective, to ensure the plan and objective were implemented per the Individualized Support Plan (ISP) and also failed for 1 additional client (client #3) to follow his wheelchair positioning plan.</p> <p>Findings include:</p> <p>1. On 05/23/12 from 3:28 PM until 6:25 PM observations at the group home were completed. On 05/23/12 at 5:25 PM, staff #1 stood to the right of client #1 and was feeding client #1 his supper. During the meal client #1's head was tilted up and back as staff #1 fed him. Staff #1 finished feeding client #1 at 6:10 PM. Client #1 was not prompted or assisted to attempt to feed himself.</p> <p>Client #1's records were reviewed on</p>	W0249	<p>All staff have been retrained on the program plans including the ISP objectives, Mealtime Guidelines, and positioning plans. The QMRP, Residential Manager, and Nurse are completing dining and positioning observations to ensure the training has been effective and that dysphagia plans/mealtime guidelines, dining objectives, and positioning plans are implemented correctly. These observations will be documented on a dining checklist and will be turned in to the Residential Director for review.</p>	06/24/2012			

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	<p>05/24/12 at 11:29 AM. Client #1's ISP dated 01/26/12 indicated client #1 had a goal to place food in his mouth given hand over hand assistance. Client #1's mealtime guidelines which contained the goal also indicated, "Staff person should be facing toward [client #1] at meals as this helps to keep him focused on the meal. Being seated and facing him will help him to maintain a neutral head position."</p> <p>On 05/24/12 at 2:00 PM an interview with the Residential Director/Registered Nurse (RD/RN) was conducted. The RD/RN indicated client #1 should have been prompted and assisted by staff to follow his plan and objective.</p> <p>2. On 05/23/12 from 3:28 PM until 6:25 PM observations at the group home were completed. On 05/23/12 at 3:28 PM, client #3 was sitting in his wheelchair and his hips and buttocks were ten inches from the back of the chair. Client #3 remained in this position until 5:40 PM when staff #2 tilted back his wheelchair and placed her arms under his arm pits and pulled him up in the chair without lifting. At 6:00 PM staff #2 used this same technique to slide client #3 up in the wheelchair.</p> <p>Client #3's records were reviewed on</p>						

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	<p>05/24/12 at 11:50 AM. Client #3's ISP dated 03/14/12 contained a "Skin Risk Protocol" which indicated he was at risk for skin breakdown and to "lift, do not slide client." The "Wheelchair Guidelines" dated 09/05/11 indicated client #3 required: "A two-man (top & bottom) lift is always required. When lifting the top portion, your arms should be under his arm pits and your hands should be grasping his forearms so that it is a snug fit and does not cause too much pressure on his joints or bones. The bottom portion can be lifted using a scooping motion under his thighs. Do not grab at the knees as this puts too much pressure on the joint and does not provide much assistance to there person lifting the top portion of his body."</p> <p>On 05/24/12 at 2:00 PM an interview with the Residential Director/Registered Nurse (RD/RN) was conducted. The RD/RN indicated client #3's wheelchair positioning guide should have been used and he required two people to properly position him.</p> <p>9-3-4(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 2 sampled clients (client #1) and 1 additional client (client #3), but not ensuring the Dysphagia Care Plan/Mealtime Guidelines included guidelines for coughing, choking and aspiration.</p> <p>Findings include:</p> <p>1. On 05/23/12 from 3:28 PM until 6:25 PM observations at the group home were completed. On 05/23/12 at 5:25 PM, staff #1 stood to the right of client #1 and was feeding client #1 his supper. During the meal client #1's head was tilted up and back as staff #1 fed him; client #1 coughed four times during the meal.</p> <p>Client #1's records were reviewed on 05/24/12 at 11:29 AM. Client #1's ISP (Individual Support Plan) dated 01/26/12 which contained client #1's dysphagia care plan/mealtime guidelines did not include any information for what the staff were to do if client #1 coughed, choked or aspirated.</p>	W0331	The dysphagia plan/mealtime guidelines have been revised to include guidelines for coughing, choking and aspiration. All staff have been trained on the revisions to the dining plans. The QMRP, Residential Manager, and Nurse are completing dining observations to ensure that the training has been effective and that plans are being implemented correctly. These observations will be documented on a dining observation checklist and will be turned in to the Residential Director for review.	06/24/2012			

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	<p>On 05/24/12 at 2:00 PM an interview with the Residential Director/Registered Nurse (RD/RN) was conducted. The RD/RN indicated the care plan should contain information for the staff regarding choking, coughing and aspiration.</p> <p>2. On 05/23/12 from 3:28 PM until 6:25 PM observations at the group home were completed. On 05/23/12 at 5:32 PM, while staff #5 was feeding client #3 his supper he began to cough. He coughed a total of 10 times.</p> <p>Client #3's records were reviewed on 05/24/12 at 11:50 AM. Client #3's ISP dated 03/14/12 which contained client #3's mealtime guidelines indicated he was at risk for choking. The guidelines did not include any information for what the staff were to do if client #3 coughed, choked or aspirated.</p> <p>On 05/24/12 at 2:00 PM an interview with the Residential Director/Registered Nurse (RD/RN) was conducted. The RD/RN indicated the care plan should contain information for the staff regarding choking, coughing and aspiration.</p> <p>9-3-6(a)</p>				

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