

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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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
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: March 28 and 29, 2012.</p> <p>Facility number: 012371 Provider number: 15G764 AIM number: 200986870</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 4/4/12 by Tim Shebel, 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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W0149	<p>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.</p> <p>Based on record review and interview, a direct care staff (DCS) neglected to follow the facility's Abuse and Neglect Policy by failing to remain awake during the overnight shift to provide supervision for 4 of 8 clients who lived in the home (clients #2, #3, #5, and #7) and were in the home at the time.</p> <p>Findings include:</p> <p>Facility records were reviewed on 3/28/12 at 12:57 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 3/28/11 and 3/28/12. The reports indicated the following:</p> <p>A BDDS report dated 7/3/11 for an incident on 7/3/11 at 5:00 A.M. indicated "On 7/3/11 at approximately 8:00 A.M. [client #5] contacted the QMRP (Qualified Mental Retardation Professional) and reported that the staff person who works the midnight shift was sleeping during the night. [Client #5] further reported she took a picture of the staff with her cell phone while he was sleeping. The staff person had already left</p>	W0149	<p>This incident occurred in July 2011. At that time, the AWS policy for Abuse and Neglect was followed and after an investigation the employee accused of falling asleep was terminated. All staff were retrained on the Abuse and Neglect policy at that time and have received retraining to adhere to the plan of correction timeline for this survey. Staff were given a post test after the retraining to ensure their understanding of the policy and the requirements for reporting. The AWS director will monitor the staff in the future to ensure that the policy is followed. Staff also receive an annual training on abuse and neglect as part of their Staff Annual Training (SAT) which is a required training that will be monitored by the director. Addendum: Managers and QMRP's are required to complete unannounced spot checks on all shift and complete a checklist which is signed by the staff present and the manager. These forms are turned into the director for review and monitoring. The clients have also received informal training on notifying staff immediately if they have any concerns about the staff.</p>	04/28/2012	

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	<p>his shift (shift ended) when the information was reported. An investigation was initiated immediately and the QMRP called the staff person and reported that he was suspended from working pending the results of the investigation. There were three other clients sleeping during this time (clients #2, #3 and #7) and the four other clients (clients #1, #4, #6 and #8) were on home visits...All of the clients were interviewed and written statements were obtained. During [client #5's] interview the picture of [DCS #12] taken by [client #5] with her cell phone was viewed and it is very clear that [DCS #12] was sleeping on the couch in the living room with a blanket over him. The allegation is substantiated due to the evidence of the staff clearly sleeping with a blanket over him on the clients (sic) cell phone...the staff [DCS #12] is terminated...The Residential Director, QMRP and Nurse were all notified...as well as the guardians of all the clients home at the time...There were no additional staff members on at the time...AWS (Anthony Wayne Services) policy/procedures do address staff sleeping on the job as potential neglect. Staff are trained on supervision levels and supervision requirements."</p> <p>The facility policy Group Home Abuse and Neglect dated 8/08 was reviewed on</p>				

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	<p>3/29/12 at 2:12 P.M. and indicated the following: "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>The Residential Director (RD) was interviewed on 3/29/12 at 2:16 P.M.. When asked about the incident of DCS #12 sleeping on shift. The RD indicated staff had not been following policy and was not to be sleeping while on shift, and was terminated due to his neglectful actions of sleeping on duty.</p> <p>9-3-2(a)</p>			