

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G727	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/27/2012
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1228 BRANDON WAY FORT WAYNE, IN 46809
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W0000	<p>This visit was for the investigation of complaint #IN00104370.</p> <p>Complaint #IN00104370: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W149, W153, and W154.</p> <p>Dates of survey: February 23 and 27, 2012.</p> <p>Facility Number: 011138 Provider Number: 15G727 AIM Number: 200824450</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 3/12/2012 by Dotty Walton, 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 observation, record review, and interview, the facility failed for 1 of 5 incidents reviewed involving 1 of 2 sampled clients (client A), to implement their policy and procedures to immediately report to the administrator an injury of unknown origin and failed to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's internal and reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/23/12 at 1:30 PM. A report dated 2/20/12 indicated staff noticed a bruise on client A's upper arm and pain with movement. After the nurse's assessment, client A was transported to a physician's office and an x-ray revealed a fracture to the upper left humerus. The report indicated an investigation had been initiated to determine the exact cause of the fracture, though the doctor treating client A's fracture indicated due to client A's osteopenia the fracture may have been caused from simple transfer or other care</p>	W0149	<p>All staff have been re-trained on the Abuse and Neglect and AWS Reportable Incidents Policies which indicates that all bruises or injuries of unknown origin must be reported to the administrator within 24 hours. The staff have completed post-tests to ensure that the training has been effective and that they understand their obligation to report and timelines for reporting.</p> <p>Additionally the nurse and the staff have received training on the documentation requirements for injuries, which includes measurements or sizes for point of reference. The director continues to make regular visits to the home to ensure that staff are following proper lifting procedures which they had received additional re-training on prior to this survey. The director will review all internal injury reports to ensure that any injuries are reported as required.</p>	03/28/2012			

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	<p>where her arm was bent at the elbow. There were no additional reports of bruising to client A to review.</p> <p>The investigative notes of the investigation still in progress were reviewed on 2/23/12 at 3:10 PM and indicated in part, "The nurse has been completing daily body checks since the bruising has been noted to make certain there are no other injuries." The investigation did not include reference to bruising to client A's facial area.</p> <p>The Regional Director was interviewed on 2/23/12 at 3:50 PM and indicated an investigation was still underway in regards to client A's fracture, staff had all been trained to use a hoier lift to transfer client A and client A's nurse was completing daily assessments on client A.</p> <p>During observation at the group home on 2/23/12 from 4:20 PM to 5:45 PM, client A had bruising (black, purple and green in color) on her upper left arm starting 3 inches from her shoulder to the elbow, a bruise (black, purple and green in color) on her left cheek 3 inches by 1 inch, and a light green bruise the size of a pea at the top of her cheek bone near the corner of her left eye.</p> <p>Client A's records in the group home were</p>						

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	<p>reviewed on 2/23/12 at 3:15 PM. Client A's nursing notes dated 2/20/12 indicated bruising to client A's upper arm, a note dated 2/21/12 indicated an appointment with an orthopaedic medical facility, treatment with a sling and a notation in which the doctor stated "she has the bones of an 80 year old. It could have occurred from simple care or transfers." A nursing note dated 2/22/12 indicated no edema to arm, continued bruising and a note dated 2/23/12 indicated client A's left arm remained in a sling and "bruising noticed." The entries did not indicate where or what size, color or shape of client A's bruising or include reference to the bruising noted to client A's facial area.</p> <p>The Regional Director was interviewed on 2/23/12 at 4:55 PM and indicated bruising was noted to client A's face on Sunday and the cause of client A's bruising and fracture was unknown and being investigated.</p> <p>Additional incident reports involving client A's injuries were reviewed on 2/27/12 at 2:30 PM and indicated an internal incident report dated 2/18/12 of a 1 and 1/2 inch bruise to client A's left cheek, purple and dark blue in color. An undated nursing note at the bottom of the report indicated a 'bruise noted to face. No edema or redness noted." There was</p>			

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	<p>no documentation that indicated the size of the bruising to client A's face upon the nurses assessment. An internal incident report dated 2/19/12 noted 2 one inch bruises on the upper left arm towards the inside, bluish in color. An undated nursing note at the bottom of the 2/19/12 report indicated "2 small bruises to arm, no swelling or redness noted with no sign and symptoms of pain." There was no documentation that indicated the size of the bruising to client A's arm upon the nurses assessment. A nursing assessment of client A dated 2/20/12 indicated client A was evaluated at 2:00 PM and found with a nickel sized bruise to the right arm, a bruise on left cheek (size not noted) and a 9 cm (centimeter) bruise to her left inner arm.</p> <p>The Regional Manager was interviewed on 2/27/12 at 3:55 PM and indicated the injury to client A's face near her eye had not been documented or reported to the administrator and the bruises to client A's face noted on 2/18/12 and to her arm on 2/19/12 had not been reported to the administrator until 2/20/12 and were unknown in origin. She indicated it was agency policy to report injuries of unknown origin within 24 hours to the administrator. She further indicated the nursing assessments had not been specific as to the size and location of client A's</p>						

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	bruising.  The facility's Policy "Incident Reports/Indiana" dated 3/2011 was reviewed on 2/23/12 at 2:55 PM and indicated in part, "Reportable incidents are any event or occurrence characterized by risk or uncertainty is not limited to resulting in or having the potential to result in significant harm or injury to an individual..., any injury to an individual when the cause of the injury is unknown and the injury requires medical evaluation or treatment, a significant injury to an individual that includes but is not limited to: a fracture; bruises or contusions larger than three inches in any direction, or a pattern of bruises or contusions regardless of size...Incident reports involving suspected or actual abuse, neglect or exploitation, or a death, are to be reported within 24 hours of the occurrence or knowledge of the occurrence..., For Investigations Involving Injuries of Unknown Origin...If the injury or death is not suspected to be the result of abuse, neglect or exploitation the investigation will include interviewing and taking written statements (as applicable) by all staff that worked with the individual prior to discovery of the injury...." The facility's policy "Reporting Abuse and Neglect" dated 4/05 indicated, "If any staff witness, observe, or suspects abuse						

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	<p>or neglect of a client, they are to report this immediately to their supervisor and the [facility name] Residential Director....."</p> <p>This federal tag relates to complaint #IN00104370.</p> <p>9-3-2(a)</p>			
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W0153	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 5 incidents reviewed involving 1 of 2 sampled clients (client A), to immediately report to the administrator an injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's internal and reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/23/12 at 1:30 PM. A report dated 2/20/12 indicated staff noticed a bruise on client A's upper arm and pain with movement. After the nurse's assessment on 2/20/12, client A was transported to a physician's office and an x-ray revealed a fracture to the upper left humerous. The report indicated an investigation had been initiated to determine the exact cause of the fracture, though the doctor treating client A's fracture indicated due to client A's osteopenia the fracture may have been caused from simple transfer or other care where her arm was bent at the elbow.</p>	W0153	<p>All staff have been re-trained on the Abuse and Neglect and AWS Reportable Incidents Policies which indicates that all bruises or injuries of unknown origin must be reported to the administrator within 24 hours. The staff have completed post-tests to ensure that the training has been effective and that they understand their obligation to report and timelines for reporting. Additionally the nurse and the staff have received training on the documentation requirements for injuries, which includes measurements or sizes for point of reference. The director continues to make regular visits to the home to ensure that staff are following proper lifting procedures which they had received additional re-training on prior to this survey. The director will review all internal injury reports to ensure that any injuries are reported as required.</p>	03/28/2012			

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	<p>The investigative notes of the investigation still in progress were reviewed on 2/23/12 at 3:10 PM and did not include reference to bruising to client A's facial area.</p> <p>During observation at the group home on 2/23/12 from 4:20 PM to 5:45 PM, client A had bruising (black, purple, and green) on her upper left arm starting 3 inches from her shoulder to the elbow, a bruise (black, purple and green) on her left cheek 3 inches by 1 inch, and a light green in color bruise the size of a pea at the top of her cheek bone near the corner of her left eye.</p> <p>Client A's records in the group home were reviewed on 2/23/12 at 3:15 PM. Client A's nursing notes dated 2/20/12 indicated bruising to client A's upper arm, a note dated 2/21/12 indicated an appointment with an orthopaedic medical facility, treatment with a sling and a notation in which the doctor stated "she has the bones of an 80 year old. It could have occurred from simple care or transfers." A nursing note dated 2/22/12 indicated no edema to arm, continued bruising and a note dated 2/23/12 indicated client A's left arm remained in a sling and "bruising noticed." The entries did not indicate where or what size, color or shape of</p>						

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	<p>client A's bruising or include reference to the bruising noted to client A's facial area.</p> <p>The Regional Director was interviewed on 2/23/12 at 4:55 PM and indicated bruising was noted to client A's face on Sunday/2/19/2012 and the cause of client A's bruising and fracture was unknown.</p> <p>Additional incident reports involving client A's injuries were reviewed on 2/27/12 at 2:30 PM and indicated an internal incident report dated 2/18/12 of a 1 and 1/2 inch bruise to client A's left cheek, purple and dark blue in color. An undated nursing note at the bottom of the report indicated a "bruise noted to face. No edema or redness noted." An internal incident report dated 2/19/12 noted 2 one inch bruises on the upper left arm towards the inside, bluish in color. An undated nursing note at the bottom of the 2/19/12 report indicated "2 small bruises to arm, no swelling or redness noted with no sign and symptoms of pain." A nursing assessment of client A dated 2/20/12 indicated client A was evaluated at 2:00 PM and found with a nickel sized bruise to the right arm, a bruise on left cheek (size not noted) and a 9 cm (centimeter) bruise to her left inner arm.</p> <p>The Regional Manager was interviewed on 2/27/12 at 3:55 PM and indicated the</p>				

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	<p>injury to client A's face near her eye had not been documented or reported to the administrator and the bruises to client A's face noted on 2/18/12 and to her arm on 2/19/12 had not been reported to the administrator until 2/20/12 and were unknown in origin. She indicated it was agency policy to report injuries of unknown origin within 24 hours to the administrator.</p> <p>This federal tag relates to complaint #IN00104370.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 5 incidents reviewed for 1 of 2 sampled clients (client A), to thoroughly investigate injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's internal and reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 2/23/12 at 1:30 PM. A report dated 2/20/12 indicated staff noticed a bruise on client A's upper arm and pain with movement. After the nurse's assessment on 2/20/12, client A was transported to a physician's office and an x-ray revealed a fracture to the upper left humerous. The report indicated an investigation had been initiated to determine the exact cause of the fracture, though the doctor treating client A's fracture indicated due to client A's osteopenia the fracture may have been caused from simple transfer or other care where her arm was bent at the elbow.</p> <p>The investigative notes of the investigation still in progress were reviewed on 2/23/12 at 3:10 PM and</p>	W0154	<p>All staff have been re-trained on the Abuse and Neglect and AWS Reportable Incidents Policies which indicates that all bruises or injuries of unknown origin must be reported to the administrator within 24 hours. The staff have completed post-tests to ensure that the training has been effective and that they understand their obligation to report and timelines for reporting. Additionally the nurse and the staff have received training on the documentation requirements for injuries, which includes measurements or sizes for point of reference. The director continues to make regular visits to the home to ensure that staff are following proper lifting procedures which they had received additional re-training on prior to this survey. The director will review all internal injury reports to ensure that any injuries are reported as required.</p>	03/28/2012			

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	<p>indicated in part, "The nurse has been completing daily body checks since the bruising has been noted to make certain there are no other injuries."</p> <p>The Regional Director was interviewed on 2/23/12 at 3:50 PM and indicated an investigation was still underway in regards to client A's fracture and client A's nurse was completing daily assessments on client A to evaluate for injury.</p> <p>During observation at the group home on 2/23/12 from 4:20 PM to 5:45 PM, client A had bruising (black, purple, and green) on her upper left arm starting 3 inches from her shoulder to the elbow, a bruise (black, purple and green) on her left cheek 3 inches by 1 inch, and a bruise (light green in color) the size of a pea at the top of her cheek bone near the corner of her left eye.</p> <p>Client A's records in the group home were reviewed on 2/23/12 at 3:15 PM. Client A's nursing notes dated 2/20/12 indicated bruising to client A's upper arm, a note dated 2/21/12 indicated an appointment with an orthopaedic medical facility, treatment with a sling and a notation in which the doctor stated "she has the bones of an 80 year old. It could have occurred from simple care or transfers." A nursing</p>				

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	<p>note dated 2/22/12 indicated no edema to arm, continued bruising and a note dated 2/23/12 indicated client A's left arm remained in a sling and "bruising noticed." The entries did not indicate where or what size, color or shape of client A's bruising.</p> <p>The Regional Director was interviewed on 2/23/12 at 4:55 PM and indicated bruising was noted to client A's face on Sunday and the cause of client A's bruising and fracture was unknown and being investigated.</p> <p>Additional incident reports involving client A's injuries were reviewed on 2/27/12 at 2:30 PM and indicated an internal incident report dated 2/18/12 of a 1 and 1/2 inch bruise to client A's left cheek, purple and dark blue in color. An undated nursing note at the bottom of the report indicated a "bruise noted to face. No edema or redness noted." There was no documentation that indicated the size of the bruising to client A's face upon the nurses assessment. An internal incident report dated 2/19/12 noted 2 one inch bruises on the upper left arm towards the inside, bluish in color. An undated nursing note at the bottom of the 2/19/12 report indicated "2 small bruises to arm, no swelling or redness noted with no sign and symptoms of pain." There was no</p>			

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	<p>documentation that indicated the size of the bruising to client A's arm upon the nurses assessment. A nursing assessment of client A dated 2/20/12 indicated client A was evaluated at 2:00 PM and found with a nickel sized bruise to the right arm, a bruise on left cheek (size not noted) and a 9 cm (centimeter) bruise to her left inner arm.</p> <p>The Regional Manager was interviewed on 2/27/12 at 3:55 PM and indicated the injury to client A's face near her eye had not been documented, reported to the administrator or investigated, and the nursing assessments had not been specific as to the size and location of client A's bruising to her face found on 2/18/12 and to her arm on 2/19/12 and were unknown in origin.</p> <p>This federal tag relates to complaint #IN00104370.</p> <p>9-3-2(a)</p>						