

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 02/06/2013
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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 #IN00122993.</p> <p>Complaint #IN00122993: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W217, W331 and W455.</p> <p>Dates of survey: January 24, 25, 28, 29, 31, February 1, 4, 5, 6, 2013.</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. Quality Review completed 2/14/13 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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W0217	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status.</p> <p>Based on interview and record review for 1 of 3 sampled clients (client A), the facility failed to assess client A's dietary needs in regards to a change in medical condition.</p> <p>Findings include:</p> <p>Client A's records were reviewed on 1/24/13 at 4:10 PM. Client A's Medication Administration Records (MARs) dated 11/12, 12/12 and 1/3/13 indicated he had diarrhea from 11/20/12-11/30/12 with the exception of 11/26/12, 12/1/12-12/10/12 and on 12/16/12, 12/17/12, 12/19/12, 12/29/12, 12/30/12, 1/1/13, 1/2/13 and 1/3/13. A Residential Services Doctor Visit Form dated 11/27/12 indicated "diarrhea, no dehydration", and under the treatment prescription section, a BRAT (bran, rice, applesauce, toast) diet and over the counter Immodium were ordered.</p> <p>Nursing notes included the following entries: 11/24/12 "Had been having some bouts of diarrhea, immodium was ordered. Staff reports it helps when given but he does have diarrhea still....," 11/27/12 "saw [Dr. Name] on 11/27 due</p>	W0217	When a new condition is diagnosed, the team will meet to look at the current plan and identify modifications needed to be addressed. Plans will be updated to include long term changes in diet or chronic conditions. The nourishment/intake record will be modified to not only monitor appetite changes but will indicate short and long term changes to the diet order. The dietician will be notified and an assessment completed. These types of modifications will be indicated on the hospital discharge summary which will be reviewed by the director for compliance.	03/08/2013			

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	<p>to continued diarrhea, he did labs and also said to keep him on a brat diet and increase him immodium..., " 11/29/12 "...labs came back with his sodium low and his creatinine a little high. To increase his water intake and to give his gatoraide (sic) instead. I told them the diarrhea was continuing..., " 12/4/12..."continues to have frequent diarrhea. Reported to primary physician and he was evaluated in the ER. While in the ER he received IV antibiotics and lab test results came back within normal limits. He returned home with no change in orders..., " 12/7/12 "...continues with diarrhea, he has been seen in the walk in clinic, [physician's office], and [hospital] ER. He is currently on antibiotics. He also remains on clear liquids on the orders of walk in clinic. Will continue to monitor occasional low grade temp..., " 12/9/12 "Food is being offered, he continues to take fluids in well diarrheas continues. Low grade temp (temperature). Will contact [Dr. Name] for further treatment, still on antibiotics..., " 12/10/12 "Called [Dr. Name] and informed him of [client A's] continuing diarrhea and now vomiting, with occasional low grade temp. Advised to go to ER once again. Taken to [hospital name] ER, ...He was admitted...." The nursing notes indicated client A experienced diarrhea during his</p>						

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	<p>hospital stay and was discharged on 12/15/12 with antibiotics, steroids, anti-diarrheal medication, regular diet and with a diagnosis of Crohn's disease (inflammatory bowel disease). Client A was seen by a physician on 12/26/12 for blisters, URI (upper respiratory illness) and diagnoses of this visit included Crohn's disease, edema, cellulitis and abscess of leg. Home Care Instructions included the following: "...There is no cure for Crohn's disease...Symptoms such as diarrhea can be controlled with medications. Avoid foods that have a laxative effect such as fresh fruit, vegetables and dairy products...Seek Immediate Medical Care If: ...An unexplained oral temperature of above 102 degrees, develops and is not controlled by medication...."</p> <p>Client A's November 2012, December 2012, and January 2013 Nourishment Intake Record indicated he was on a regular diet, chop food into small bites. There was no evidence client A's diet was modified to a BRAT diet, or to avoid fruits, vegetables and dairy products in the intake record. Client A's nutritional assessment dated October 2012 indicated he received a regular diet and included a diagnosis of constipation. There was no evidence of an updated evaluation of client A's nutritional status since the onset</p>						

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	<p>of diarrhea or the diagnosis of Crohn's disease.</p> <p>The group home nurse was interviewed on 1/28/13 at 4:04 PM. She indicated the dietitian had not reviewed client A's nutritional status since the onset of diarrhea or the diagnosis of Crohn's disease, and facility staff had encouraged client A to eat while avoiding dairy and fruit.</p> <p>This federal tag relates to complaint #IN00122993.</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 upon observation, record review and interview, the facility's nursing services failed for 2 of 2 sampled clients (clients A and B) to develop and document a system to monitor the clients' response to treatment for their medical conditions.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to BDDS (Bureau of Developmental Disabilities Services) were reviewed on 1/24/13 at 3:40 PM. A report dated 12/4/12 indicated client A was assessed in the ER (emergency room) for prolonged diarrhea and to evaluate for dehydration. The report indicated client A was given fluids and labs which were within normal limits. Client A was released with instructions to place him on a liquid diet which was done. A report dated 12/10/12 indicated client A was taken to the hospital for prolonged diarrhea and admitted for evaluation and treatment. Client A was discharged from the hospital on 12/18/12 with a diagnosis of Crohn's disease (inflammatory bowel disease). The treatment included steroid therapy with a regular diet. A report dated 1/7/13</p>	W0331	<p>The nurse will receive retraining which will include that all orders for vital signs, increased due to condition or routine, will be placed on the MAR or a flow sheet which can be added to the MAR. All clients have parameters listed on their MAR of acceptable vital signs and when to contact the nurse. All staff, including the nurse have received re-training on the vital orders and their responsibility to notify the nurse if vitals are above or below the indicated parameters. Staff have also received retraining on the PRN policy and how to monitor and document effectiveness within an hour of a PRN being administered. The manager, QMRP, nurse and director will complete Medication Administration Record Audit form and ensure that staff understand the information they have been trained on and to monitor compliance. These types of modifications will be indicated on the hospital discharge summary, when applicable which will be reviewed by the director for compliance. The director will also review the MAR's/MAR Audit form to ensure compliance.</p> <p>When a new condition is diagnosed, the team will meet to look at the current plan and</p>	03/08/2013			

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	<p>indicated client A had died after experiencing diarrhea, agitation and being unable to keep his head upright. Client A's vital signs were taken and staff were unable to get a blood pressure. Staff began CPR and called 911. Client A was pronounced dead by the paramedics. A death certificate dated 1/10/13 indicated the cause of death was hydrocephalus (fluid on the brain).</p> <p>Client A's records were reviewed on 1/24/13 at 4:10 PM. Client A's Medication Administration Records (MARs) dated 11/12, 12/12 and 1/13 indicated he had diarrhea from 11/20/12-11/30/12 with the exception of 11/26/12, 12/1/12-12/10/12 and on 12/16/12, 12/17/12, 12/19/12, 12/29/12, 12/30/12, 1/1/13, 1/2/13 and 1/3/13. The MARs did not include documentation of client A's temperature. A Residential Services Doctor Visit Form dated 11/27/12 indicated "diarrhea, no dehydration", and under the treatment prescription section, a BRAT (bran, rice, applesauce, toast) diet and over the counter Immodium were ordered. Health Issues/Nursing Notes included the following entries: 11/24/12 "Had been having some bouts of diarrhea, immodium was ordered. Staff reports it helps when given but he does have diarrhea still...," 11/27/12 "saw [Dr.</p>		<p>identify modifications needed to be addressed. Plans will be updated to include long term changes in diet or chronic conditions. The nourishment/intake record will be modified to not only monitor appetite changes but will indicate short and long term changes to the diet order. The dietician will be notified and an assessment completed. These types of modifications will be indicated on the hospital discharge summary which will be reviewed by the director for compliance.</p>				

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	Name] on 11/27 due to continued diarrhea, he did labs and also said to keep him on a brat diet and increase his immodium...," 1129/12 "...labs came back with his sodium low and his creatinine a little high. To increase his water intake and to give him gatoraide (sic) instead. I told them the diarrhea was continuing...," 12/4/12..."continues to have frequent diarrhea. Reported to primary physician and he was evaluated in the ER. While in the ER he received IV antibiotics and lab test results came back within normal limits. He returned home with no change in orders...," 12/7/12 "...continues with diarrhea, he has been seen in the walk in clinic, [physician's office], and [hospital] ER. He is currently on antibiotics. He also remains on clear liquids on the orders of walk in clinic. Will continue to monitor occasional low grade temp...," 12/9/12 "Food is being offered, he continues to take fluids in well diarrheas continues. Low grade temp (temperature). Will contact [Dr. Name] for further treatment, still on antibiotics...," 12/10/12 "Called [Dr. Name] and informed him of [client A's] continuing diarrhea and now vomiting, with occasional low grade temp. Advised to go to ER once again. Taken to [hospital name] ER, ...He was admitted...." The nursing notes indicated client A experienced diarrhea during his			

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	<p>hospital stay and was discharged on antibiotics, steroids, anti-diarrheal medication, regular diet and with a diagnosis of Crohn's disease. Client A was seen by a physician on 12/26/12 for blisters, URI (upper respiratory illness) and diagnoses of this visit included Crohn's disease, edema, cellulitis and abscess of leg. Home Care Instructions included the following: "...There is no cure for Crohn's disease...Symptoms such as diarrhea can be controlled with medications. Avoid foods that have a laxative effect such as fresh fruit, vegetables and dairy products...Seek Immediate Medical Care If: ...An unexplained oral temperature of above 102 degrees, develops and is not controlled by medication..."</p> <p>Client A's November 2012, December 2012, and January 2013 Nourishment Intake Record indicated he was on a regular diet, chop food into small bites. There was no evidence in the record client A's diet was modified to a BRAT diet, or to avoid fruits, vegetables and dairy products in the intake record.</p> <p>The group home nurse was interviewed on 1/28/13 at 4:04 PM. She indicated facility staff had encouraged client A to eat while avoiding dairy and fruit.</p>			

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	<p>The group home nurse was interviewed again on 2/5/13 at 4:45 PM and indicated client A's diet had been informally altered to address the physician's orders of the BRAT diet and of the recommendation to avoid fruit and dairy products but it had not been documented in client A's nutritional intake records.</p> <p>The Residential Director was was interviewed on 2/6/13 at 4:41 PM and indicated client A's temperatures were not monitored and should have been documented on the MAR.</p> <p>2. A report dated 12/16/12 indicated client B had been taken to the ER because of an increased body temperature of 102 degrees and had experienced an episode of vomiting. Client B had been receiving antibiotics since her primary care physician had diagnosed her with pneumonia and an ear infection on 12/13/12. Client B experienced a compromised respiratory status after being admitted to the ICU (intensive care unit) and required a ventilator to ease her respiratory struggles, and received a picc (peripherally inserted central catheter) line to assist with antibiotic therapy.</p> <p>Client B's record was reviewed on 1/24/13 at 5:58 PM. Health Issues/Nursing Notes included the</p>			

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	<p>following entries by staff: 12/5/12, "went to see [Dr. Name] GI (gastrointestinal) for the blood in her stools, put her on suppository." An entry dated 12/16/12 indicated client B went into the hospital. Entries by the nurse included 12/5/12, loose brown stool, afebrile. 12/7/12 indicated client B went to the doctor on 12/5/12, "he found no evidence of bleeding noted. He wants us to continue to monitor and follow up for any new bleeding. She sounds much better (sic) was on antibiotic x 3 days for acute bronchitis. 12/10/12 Afebrile...continues with chronic congestion, receives nebulizer treatments as prescribed...no further rectal tarry (dark red or black) stools noted." 12/12 "saw [Dr. Name] for increased coughing and low grade temp (temperature). Chest x-ray done and she was started on antibiotic which was changed to amox (amoxicillin) after chest X-ray viewed and noted pneumonia. 12/16/12 "[client B] spiked a temp (temperature) this evening and vomited x 1 transported per van to [name] hospital. She was admitted once the X-rays showed increasing pneumonia. She was placed in ICU..." 12/22/12 discharged in satisfactory condition.</p> <p>A 3/22/12 Nursing Care Plan indicated client B's vital signs were to be monitored monthly, "unless condition warrants more</p>			

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	frequent monitoring. Temperature to be taken every evening and recorded. Report significant changes to physician..Obtain O 2 saturation twice daily to monitor for any signs and symptoms of decreased respiratory status..." Client B's MAR for December, 2012 indicated she received Tylenol for temperature 5 times on 12/2, 5 times on 12/3, 4 times on 12/4, and twice on 12/5. There was no evidence of client B's temperature being monitored or documented for the response of the Tylenol she was given. Client B's temperature was taken daily before her shower (time not indicated) with the exception of 12/17-21/12 which did not indicate an elevated temperature. There was no documented evidence of increased monitoring of client B's temperature after she was diagnosed with pneumonia on 12/16/12. A handwritten note on the back of the temperature page indicated on 12/4/12 client B had a temperature of 100.6 and the nurse was notified. Oxygen sats (saturations) were taken 4 times daily before and after nebulizer treatment and indicated staff were to notify the on-call if below 90. On 12/2 client B's sats were 86 and 88 at 6:00 AM, and 87 at 12:00 PM, on 12/3/12, sats were 88 and 89 at 6:00 AM and 88 at 12:00 AM, on 12/4/12 sats were 83 and 86 at 6:00 AM and 88 at 12:00 AM, on 12/5/12 the sats were 83 at 12:00 AM. There was no evidence of the			

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	<p>on call or nurse being notified of client B's reduced sats. The MAR indicated client B had received Anucort HC 25 mg (milligrams) suppository daily starting 12/12/12.</p> <p>The group home nurse was interviewed on 2/5/13 at 4:45 PM and indicated client B's temperature was not monitored more than daily as there were no doctor's orders to do so. She indicated staff had called the nurse on 12/4/12 to notify of the reduced O 2 sats and had documented it on the back of the page where temperatures were recorded, but there was no other evidence of the nurse or on call having been called when client B's O 2 sats were below 90. She indicated some temperatures for client B had been recorded in the staff log notes and she would provide the evidence. She indicated client B was prescribed Anucort-HC suppository after her doctor's visit on 12/5/12.</p> <p>Staff log notes for December, 2012 were reviewed on 2/5/13 at 5:20 PM. A note by the nurse dated 12/2/12 indicated client B had an increased temperature of 100.5 at 7:00 AM, and a call had been made to the doctor. "Monitor closely, leave in bed, turn every 2 hours, take temp every 4 hours before Tylenol, give her Tylenol even if no temp every 4</p>				

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	<p>hours...." There was no additional evidence of client B being monitored for temperature every 4 hours as indicated.</p> <p>The Residential Director was interviewed on 2/6/13 at 4:41 PM and and indicated she was unsure as to why client B's Anucort was not given until 12/12/12 after being prescribed by the doctor on 12/5/12. She indicated it was the doctor and the nurse's responsibility to determine monitoring needs for clients' changing medical conditions and vital signs should be documented on the MAR.</p> <p>This federal tag relates to complaint #IN00122993.</p> <p>9-3-6(a)</p>			

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W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview for 1 of 2 sampled clients (client B), the facility failed to ensure staff implemented hand washing during medication administration via G-tube.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 1/24/13 from 5:30 PM until 7:15 PM. At 6:50 PM, staff #1 administered client B's medications via G-tube. During the medication pass, liquid came up from client B's tube and spilled onto her wheelchair cushion. Staff #1 wiped the spill with a paper towel, touching the seat cushion in the process. Staff #1 started to complete the administration of the remainder of client B's medications before the surveyor inquired if she was to wash her hands, and stopped to wash her hands.</p> <p>Staff #1 was interviewed on 1/24/13 at 6:55 PM. She indicated she should have washed her hands before administering the remainder of client B's medications after cleaning up the spilled liquid.</p> <p>The group home nurse was interviewed on 1/28/13 at 4:04 PM. She indicated staff should wash their hands after contamination and prior to administering medications.</p> <p>This federal tag relates to complaint #IN00122993.</p>	W0455	All staff have received retraining on appropriate infection control policies which include hand washing during medication administration. The manager, QMRP, nurse and director will complete Medication Administration Record Audit form and ensure that staff understand the information they have been trained on and to monitor compliance. All the MAR audits will be turned into the director to review compliance and proper monitoring.	03/08/2013			

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 02/06/2013
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	9-3-7(a)				