

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 10/30/12, 10/31/12, 11/1/12 and 11/2/12.</p> <p>Facility Number: 000904 Provider Number: 15G390 AIMS Number: 100233320</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/9/12 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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the governing body failed to exercise budgeting and operating direction over the facility to ensure the facility did not allow clients to pay for personal hygiene items.</p> <p>Findings include:</p> <p>1. Client #1's financial record was reviewed on 11/1/12 at 11:53 AM. Client #1's PSPCR's (Personal Spending Petty Cash Receipt) indicated the following:</p> <p>-local department store receipt, 10/4/12, purchased bodywash for a total of \$3.49 USD (United States Dollars).</p> <p>-local department store receipt, 8/12, purchased bodywash and toothpaste for a total of \$7.39 USD.</p> <p>2. Client #2's financial record was reviewed on 11/1/12 at 12:00 PM. Client #2's PSPCR's indicated the following:</p> <p>-local department store receipt, 8/7/12, purchased bodywash and toothpaste for a total of \$7.91 USD.</p>	W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Corrective action for resident(s) found to have been affected AWS will reimburse Client #1 \$10.88 USD for personal hygiene items purchased. AWS will reimburse Client #2 \$7.91 USD for personal hygiene items purchased. AWS will reimburse Client #3 \$11.95 USD for personal hygiene items purchased. AWS will reimburse Client #4 \$20.36 for personal hygiene items purchased. AWS does have a policy to pay for all personal hygiene items for consumers living in the group homes.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence AWS does have a policy to provide all personal hygiene items. All personal hygiene items will be purchased by AWS for all consumers living in the group</p>	11/30/2012			

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	<p>3. Client #3's financial record was reviewed on 11/1/12 at 12:08 PM. Client #3's PSPCR's indicated the following:</p> <p>-local department store receipt, 10/29/12, purchased bodywash for a total of \$5.23 USD.</p> <p>-local department store receipt, 9/24/12, purchased shampoo for a total of \$2.99 USD.</p> <p>-local department store receipt, 8/1/12, purchased bodywash for a total of \$3.73 USD.</p> <p>4. Client #4's financial record was reviewed on 11/1/12 at 12:15 PM. Client #4's PSPCR's indicated the following:</p> <p>-local department store receipt, 10/29/12, purchased toothpaste and bodywash for a total of \$10.42 USD.</p> <p>-local department store receipt, 9/11/12, purchased bodywash for a total of \$3.53 USD.</p> <p>-local department store receipt, 8/8/12, purchased bodywash and toothpaste for a total of \$6.41 USD.</p> <p>Interview with TL (Team Leader) #1 on</p>		<p>home. All staff, Team Leaders, and the Group Home Manager will be retrained on this by the QDDP. The Regional Director will sign off on this training.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The Team Leader and Group Home Manager will sign off on all monthly spending money ledgers. These will be forwarded to the Regional Director to ensure compliance who will sign off and then send to the AWS compliance department.</p>				

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	<p>11/1/12 at 12:05 PM indicated the facility did not provide hygiene items for the clients. TL #1 indicated clients purchased their own hygiene items from the store.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 and HM (Home Manager) #1 on 11/1/12 at 12:25 PM indicated the facility did not provide hygiene items for the clients. HM #1 indicated the clients received a monthly payment from medicaid/medicare that was used for their personal hygiene items. HM #1 indicated the clients/guardians were notified the facility would not provide hygiene items upon their admission. QMRP #1 indicated the company policy was to not provide hygiene items for the clients.</p> <p>9-3-1(a)</p>				

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (#4), the ISP (Individual Support Plan) and BSP (Behavior Support Plan) failed to address the client's identified behavioral needs regarding dental/medical procedure anxiety.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 11/1/12 at 9:00 AM. Client #4's medication script dated 4/4/12 indicated, "Xanax (sedative) 1 milligram. Take one tablet at 6:00 AM on day of dental appointment and another tablet 30 minutes prior to dental appointment." Client #4's electronic health record form dated 10/5/11 indicated, "[Client #4] presents for recall with her caretaker, [TL (team leader) #1], who reports no complaints and no changes to medical history. [Client #4] has had Xanax as ordered with little effect today." Client #4's ISP (Individual Support Plan) dated 9/7/11 did not indicate training or supports for medical/dental procedure anxiety. Client #4's BSP (Behavior</p>	W0227	<p>The individual program plans state the specific needs necessary to meet the client's needs. Corrective action for resident(s) found to have been affected The Behavior Clinician responsible for ensuring the Behavior Support Plan is in place, complete and accurate will update the BSP to include a desensitization plan for any consumer needing psychotropic medications for physician visits. The QDDP responsible for programming will seek guardian approval and ensure the BSP is complete and accurate. Staff will be trained on all updated BSPs by the BC or a supervisor trained by the BC. How facility will identify other residents potentially affected and what measures taken All residents with orders to receive psychotropic medications for physician visits are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Monitoring the BSP and physician orders will be added to the</p>	11/30/2012			

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	<p>Support Plan) revised 8/28/11 did not indicate training or supports for medical/dental procedure anxiety.</p> <p>Interview with BC (Behavior Consultant) #1 on 11/1/12 at 11:30 AM indicated client #4's BSP did not include support or training for medical/dental procedure anxiety.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/1/12 at 11:35 AM indicated client #4's ISP did not include support or training for medical/dental procedure anxiety.</p> <p>9-3-4(a)</p>		<p>quarterly meeting checklist. The team including the BC, QDDP, and LPN will compare the physician orders to the BSP at each quarterly to ensure compliance as well as assure the inclusion of necessary medical/dental appointment anxiety support. The QDDP is responsible for the meeting agenda.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The QDDP will follow up to ensure the BC updates all BSPs and all staff are trained on all new or updated plans by the BC or a supervisor trained by the BC. The Regional Director will be sent the meeting checklist following each consumer meeting by the QDDP to ensure compliance. The Regional Director will sign off, and will return the agenda to the QDDP to maintain in the client file.</p>				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the facility's HRC (human rights committee) failed to review, approve and monitor restrictive practices regarding the use of psychotropic medications.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 11/1/12 at 10:00 AM. Client #3's physician's prescription form dated 1/18/12 indicated an order for risperdal (antipsychotic) 1 milligram PO (by mouth) BID (twice a day). Client #3's physicians prescription form dated 7/20/12 indicated an order for Trazodone (sedative) 50 milligrams one half tablet QHS (at bedtime) and risperdal 1 milligram one half tablet in AM and one tablet QHS. Client #3's HCCMR (health care coordination monthly review) form for July 2012 indicated, "D/C (discontinue) risperdal one milligram BID, start risperdal one milligram one half tablet in AM and one tablet HS (bedtime) for impulse control." Client</p>	W0262	<p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Corrective action for resident(s) found to have been affected The LPN is responsible for seeking HRC approval for a new or changed psychotropic medication order. Once HRC approval is received, the LPN will seek guardian approval and will update the BC who will update the BSP. The QDDP responsible for programming will ensure the BSP is complete and accurate. Staff will be trained on all new or updated BSPs by the BC or a supervisor trained by the BC.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents receiving psychotropic medications are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Monitoring the BSP and physician</p>	11/30/2012			

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	<p>#3's HCCMR form for September 2012 indicated, "D/C risperdal 0.5 milligram in AM and 1 milligram in HS, start risperdal 2 milligram HS. Client #3's physician's order form dated 10/21/12 indicated client #3 received risperidone 2 milligram tablet orally at bedtime and trazodone 50 milligram tablet one half tablet/25 milligrams orally at bedtime. Client #3's HRC (human rights committee) form dated 12/19/11 did not indicate review or approval for the use of risperdal or trazodone. Client #3's record did not indicate the facility HRC had reviewed or approved the use of risperdal or trazodone for client #3.</p> <p>2. Client #4's record was reviewed on 11/1/12 at 9:00 AM. Client #4's physician's prescription form dated 4/4/12 indicated, "xanax (sedative) 1 milligram. Take one tablet at 6:00 AM on day of dental appointment and another tablet 30 minutes prior to dental appointment." Client #4's electronic health record form dated 10/5/11 indicated, "[Client #4] presents for recall with her caretaker, [TL (team leader) #1], who reports no complaints and no changes to medical history. [Client #4] has had Xanax as ordered with little effect today." Client #4's HRC form dated 10/17/11 did not indicate review or approval for the use of xanax 1 milligram tablet. Client #4's</p>		<p>orders will be added to the meeting checklist. The team including the BC, QDDP, and LPN will compare the physician orders to the BSP at each quarterly to ensure compliance and HRC approval. The QDDP is responsible for the meeting agenda.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The QDDP will follow up to ensure the BC updates all BSPs and all staff are trained on new or updated plans.</p> <p>The Regional Director will be sent the meeting checklist following each consumer meeting by the QDDP to ensure compliance. The Regional Director will sign off, and will return the agenda to the QDDP to maintain in the client file.</p>				

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	<p>record did not indicate the facility HRC had reviewed or approved the use of xanax 1 milligram tablet.</p> <p>Interview with BC (Behavior Consultant) #1 on 11/1/12 at 11:30 AM indicated the facility did not have HRC approval/review for client #3's use of risperdal and/or trazodone. BC #1 indicated the facility did not have HRC approval/review for client #4's use of xanax.</p> <p>9-3-4(a)</p>				

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain the health care representative (HCR) or guardian's approval before implementation of a BSP (Behavior Support Plan) or behavioral medications for 2 of 4 sampled clients (#3 and #4).</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 11/1/12 at 10:00 AM. Client #3's physician's prescription form dated 1/18/12 indicated an order for risperdal (antipsychotic) 1 milligram PO (by mouth) BID (twice a day). Client #3's physicians prescription form dated 7/20/12 indicated an order for Trazodone (sedative) 50 milligrams one half tablet QHS (at bedtime) and risperdal 1 milligram one half tablet in AM and one tablet QHS. Client #3's HCCMR (health care coordination monthly review) form for July 2012 indicated, "D/C (discontinue) risperdal one milligram BID, start risperdal one milligram one half tablet in AM and one tablet HS (bedtime) for impulse control." Client</p>	W0263	<p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents, or legal guardian.</p> <p>Corrective action for resident(s) found to have been affected The LPN is responsible for seeking HRC approval for a new or changed psychotropic medication order. Once HRC approval is received, the LPN will seek guardian approval and will update the BC who will update the BSP. The QDDP responsible for programming will ensure the BSP is complete and accurate. Staff will be trained on all new or updated BSPs by the BC or a supervisor trained by the BC.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents receiving psychotropic medications are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Monitoring the BSP and physician orders will be added to the meeting checklist. The team including the BC, QDDP, and</p>	11/30/2012			

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	<p>#3's HCCMR form for September 2012 indicated, "D/C risperdal 0.5 milligram in AM and 1 milligram in HS, start risperdal 2 milligram HS. Client #3's physician's order form dated 10/21/12 indicated client #3 received risperidone 2 milligram tablet orally at bedtime and trazodone 50 milligram tablet one half tablet/25 milligrams orally at bedtime. Client #3's ISP (Individual Support Plan) dated 9/4/12 indicated client #3 had a HCR. Client #3's record did not indicate the facility had obtained written informed consent from the HCR for the use of risperdal or trazodone.</p> <p>2. Client #4's record was reviewed on 11/1/12 at 9:00 AM. Client #4's physician's prescription form dated 4/4/12 indicated, "xanax (sedative) 1 milligram. Take one tablet at 6:00 AM on day of dental appointment and another tablet 30 minutes prior to dental appointment." Client #4's electronic health record form dated 10/5/11 indicated, "[Client #4] presents for recall with her caretaker, [TL (team leader) #1], who reports no complaints and no changes to medical history. [Client #4] has had Xanax as ordered with little effect today." Client #4's HRC form dated 10/17/11 did not indicate review or approval for the use of xanax 1 milligram tablet. Client #4's record did not indicate the facility HRC</p>		<p>LPN will compare the physician orders to the BSP at each quarterly to ensure compliance, HRC approval, and guardian approval. The QDDP is responsible for the meeting agenda.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The QDDP will follow up to ensure the BC updates all BSPs and all staff are trained on new or updated plans. The Regional Director will be sent the meeting checklist following each consumer meeting by the QDDP to ensure compliance. The Regional Director will sign off, and will return the agenda to the QDDP to maintain in the client file.</p>				

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	<p>had reviewed or approved the use of xanax 1 milligram tablet. Client #4's ISP dated 9/7/11 indicated client #4 had a HCR. Client #4's record did not indicate the facility had obtained written informed consent for the use of xanax.</p> <p>Interview with BC (Behavior Consultant) #1 on 11/1/12 at 11:30 AM indicated the facility did not have written informed consent for client #3's use of risperdal and/or trazodone. BC #1 indicated the facility did not have written informed consent for client #4's use of xanax.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/1/12 at 11:35 AM indicated the facility did not have written informed consent for client #3's use of risperdal and/or trazodone. QMRP #1 indicated the facility did not have written informed consent for client #4's use of xanax.</p> <p>9-3-4(a)</p>						

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W0312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 4 sampled clients (#3) who used behavior controlling drugs, the client's program failed to include the use of and withdrawal criteria for psychotropic medication used for behavior management.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/1/12 at 10:00 AM. Client #3's physician's prescription form dated 1/18/12 indicated an order for risperdal (antipsychotic) 1 milligram PO (by mouth) BID (twice a day). Client #3's physicians prescription form dated 7/20/12 indicated an order for Trazodone (sedative) 50 milligrams one half tablet QHS (at bedtime) and risperdal 1 milligram one half tablet in AM and one tablet QHS. Client #3's HCCMR (health care coordination monthly review) form for July 2012 indicated, "D/C (discontinue) risperdal one milligram BID, start risperdal one milligram one half tablet in AM and one tablet HS (bedtime) for impulse control." Client #3's HCCMR form for September 2012 indicated, "D/C risperdal 0.5 milligram in AM and 1 milligram in HS, start risperdal 2 milligram HS. Client #3's physician's order form dated 10/21/12 indicated client #3 received risperidone 2 milligram tablet orally at bedtime and trazodone 50 milligram tablet one half tablet/25 milligrams orally at bedtime. Client #3's BSP (behavior</p>	W0312	<p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Corrective action for resident(s) found to have been affected The BC will update the BSP to include a titration plan or plan of reduction for any consumer prescribed a psychotropic medication. The BC or supervisor trained by the BC will train all staff on the updated BSP. How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers. Measures or systemic changes facility put in place to ensure no recurrence A pharmacist comes to the group homes quarterly to check medications and discuss titration plans. The recommendations by the pharmacist along with the physician orders and the responses from the IDT will determine the necessary titration</p>	11/30/2012			

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	<p>support plan) dated 8/22/11 did not indicate the use of risperdal or trazodone and a plan of reduction.</p> <p>Interview with BC (Behavior Consultant) #1 on 11/1/12 at 11:30 AM indicated client #3's BSP did not include the use or titration of risperdal or trazodone.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 11/1/12 at 11:35 AM indicated client #3's BSP did not include the use or titration of risperdal or trazodone.</p> <p>9-3-5(a)</p>		<p>plan. The IDT recommended titration plan will be included in the BSP by the BC. The QDDP is responsible for ensuring the BSPs are updated and complete and reviewed for HRC approval. The QDDP will seek guardian approval for any new or updated BSP. How corrective actions will be monitored to ensure no recurrence Monitoring the BSP and physician orders will be added to the meeting checklist. The team including the BC, QDDP, and LPN will compare the physician orders to the BSP at each quarterly to ensure compliance, HRC approval, and guardian approval. The QDDP is responsible for the meeting agenda. The Regional Director will be sent the meeting checklist following each consumer meeting by the QDDP to ensure compliance. The Regional Director will sign off, and will return the agenda to the QDDP to maintain in the client file.</p>		

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventative and general medical care. Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to provide an annual physical examination.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/31/12 at 2:08 PM. Client #1's physical form dated 6/6/11 indicated an annual physical assessment had been completed. Client #1's record did not indicate an annual physical assessment had been completed since the 6/6/11 physical.</p> <p>2. Client #4's record was reviewed on 11/1/12 at 9:00 AM. Client #4's physical form dated 9/8/11 indicated an annual physical assessment had been completed. Client #4's record did not indicate an annual physical assessment had been completed since the 9/8/11 physical.</p> <p>Interview with LPN (licensed practical nurse) #1 on 11/1/12 at 11:30 AM indicated clients #1 and #4 did not have a more current annual physical assessment for review. LPN #1 indicated the annual physical assessment should be completed yearly.</p>	W0322	<p>The facility must provide or obtain preventative and general medical care.</p> <p>Corrective action for resident(s) found to have been affected All consumers must have a physical annually. The physical for Client #1 was obtained 11-14-12. The physical for Client #4 has been scheduled for 11-30-12.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence The LPN has included on the monthly nursing summary the dates of each client's last physical. This will ensure the dates are reviewed monthly to ensure compliance. Also these dates will be included on the meeting checklist that will be reviewed at each quarterly meeting and signed off on by the Regional Director.</p> <p>How corrective actions will be monitored to ensure no recurrence The LPN's monthly nursing summary is sent to the QDDP</p>	11/30/2012			

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	9-3-6(a)		monthly to include in the QDDP's monthly programming summary. These dates will be viewed monthly by the QDDP to ensure compliance. The monthly programming summary is sent to the AWS compliance department. The dates will also be included and reviewed on the meeting checklist. This will be sent to the Regional Director after each meeting to be reviewed and signed off on. The original will then be returned to the QDDP to be maintained in the client's file.		

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W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure annual TB (Tuberculosis) testing, x-ray or symptom checklist screening was completed.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/31/12 at 2:08 PM. Client #1's physical form dated 6/6/11 indicated an annual TB testing was completed. Client #1's record did not indicate an annual TB testing, x-ray or symptom checklist screening had been completed since the 6/6/11 TB test.</p> <p>2. Client #4's record was reviewed on 11/1/12 at 9:00 AM. Client #4's physical form dated 9/8/11 indicated an annual TB testing was completed. Client #4's record did not indicate an annual TB testing, x-ray or symptom checklist screening had been completed since the 9/8/11 TB test.</p> <p>Interview with LPN (licensed practical nurse) #1 on 11/1/12 at 11:30 AM</p>	W0327	<p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.</p> <p>Corrective action for resident(s) found to have been affected All consumers must have a physical annually which includes a TB test. The physical and TB test for Client #1 was obtained 11-14-12. The physical and TB test for Client #4 has been scheduled for 11-30-12.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p>	11/30/2012			

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	<p>indicated clients #1 and #4 did not have a more current TB testing, x-ray or symptom checklist screening for review. LPN #1 indicated the TB testing, x-ray or symptom checklist screening assessment should be completed yearly.</p> <p>9-3-6(a)</p>		<p>The LPN has included on the monthly nursing summary the dates of each client's last physical and TB test. This will ensure the dates are reviewed monthly to ensure compliance. These dates will be included on the meeting checklist that will be reviewed at each quarterly meeting and signed off on by the Regional Director.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The LPN's monthly nursing summary is sent to the QDDP monthly to include in the QDDP's monthly programming summary. These dates will be viewed monthly by the QDDP to ensure compliance. The monthly programming summary is sent to the AWS compliance department. The dates will also be included and reviewed on the meeting checklist. This will be sent to the Regional Director after each quarterly meeting to be reviewed and signed off on. The original will then be returned to the QDDP to be maintained in the client's file.</p>		

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 4 sampled clients (#1 and #3) plus 4 additional clients (#5, #6, #7 and #8), the facility nurse failed to ensure all drugs were administered in compliance with he clients' physicians orders.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 10/30/12 at 12:44 PM. The review indicated the following:</p> <p>-BDDS report dated 6/1/12 indicated client #8 was administered 1 of a 2 pill dosage of Sertraline (depression) 100 milligram pills.</p> <p>-BDDS report dated 7/30/12 indicated client #8 was not given her 9:00 PM dose of zolpidem titrate (sedative) 10 milligram on 7/29/12.</p> <p>-BDDS report dated 8/2/12 indicated client #3 was not given her 7:00 AM dose or risperdal (antipsychotic) 1 milligram one half tablet.</p>	W0368	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Corrective actionfor resident(s) found tohave been affected All staff will be retrained on Medication Administration in a Core A Core B refresher course taught by the Group Home LPN. This medication administration training will include the appropriate way to pass medication and the appropriate way to measure liquid medication. The Team Leaders will observe one medication pass for each staff monthly How facilitywill identify otherresidents potentially affectedand what measures taken All residents are affected and corrective action will address the needs of all clients. Measures orsystemic changes facilityput in place toensure no recurrence The Team Leaders will observe one medication pass for each staff monthly. This will ensure staff are continually passing medications as trained in Core A Core B. The Director of Health Services at AWS is currently working on</p>	11/30/2012	

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	<p>-BDDS report dated 8/25/12 indicated, "...since August 21 [client #7] has only been getting one tablet of her vitamin D3 (supplement) instead of the prescribed two tablets."</p> <p>-BDDS report dated 9/21/12 indicated, "After returning from an outing with her family at approximately 5:15 PM [client #1] was not given her glipizide (diabetes) 5 milligram within her one hour window."</p> <p>-BDDS report dated 9/20/12 indicated client #5 had received a peer's acetaminophen (pain management) 325 milligram dose.</p> <p>-BDDS report dated 10/15/12 indicated, "... on 10/13/12 staff noticed the (sic) [client #6] phenobarbital (seizures) 64.8 milligram for the (sic) that PM was still in the packaging. The staff contacted the group home nurse of the error and they were instructed to go ahead and give the medication. The next morning staff went to administer the same medication and discovered that the pill was missing from the AM and had been given last night by mistake at 8:00 PM. As a result of there (sic) errors [client #6] received the medication 3 times: 7:00 AM, 8:00 PM and then again at 10:00 PM."</p> <p>-BDDS report dated 10/22/12 indicated</p>		<p>revising the internal Core A Core B curriculum to ensure staff are appropriately and comprehensively being trained in Medication Administration.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations monthly. The Regional Director will ensure all Group Home staff receive this retraining and will sign off on all Record of Trainings.</p>		

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	<p>client #5 was, "given her nightly dose of donepezil hcl (hydrochloric) (dementia) 10 milligram tablet twice, once at 7:00 PM and again at 8:00 PM. The pill is prescribed to be taken on an empty stomach so it is given prior to the rest of the medication. When it came time for the remainder of her medication to be given at 8:00 PM the pill was administered again."</p> <p>Client #1's record was reviewed on 10/31/12 at 2:08 PM. Client #1's PO (physician's orders) dated 10/21/12 indicated client #1 had an order for glipizide 5 milligram tablet, 1/2 tablet (2.5 milligrams) orally every evening/5:00 PM for diabetes.</p> <p>Client #3's record was reviewed on 11/1/12 at 10:00 AM. Client #3's physicians prescription form dated 1/18/12 indicated an order for risperdal 1 milligram PO (by mouth) BID (twice a day).</p> <p>Client #5's PO dated 10/21/12 was reviewed on 11/2/12 at 2:42 PM. Client #5's PO indicated client #5 had an order for acetaminophen 325 milligram tablet and donepezil HCL 10 milligram tablet.</p> <p>Client #6's PO dated 10/21/12 was reviewed on 11/2/12 at 2:44 PM. Client</p>				

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	<p>#6's PO indicated client #6 had an order for phenobarbital 64.8 milligrams.</p> <p>Client #7's PO dated 10/21/12 was reviewed on 11/2/12 at 2:45 PM. Client #7's PO indicated client #7 had an order for vitamin D3 two tablets 2000 units orally two times a day.</p> <p>Client #8's PO dated 10/21/12 was reviewed on 11/2/12 at 2:48 PM. Client #8's PO indicated client #8 had an order for sertraline 100 milligrams 2 tablets and zolpidem titrate 10 milligrams.</p> <p>Interview with LPN (licensed practical nurse) #1 on 10/31/12 at 11:15 AM indicated clients should receive medication as ordered by their physician.</p> <p>9-3-6(a)</p>				

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W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#3) plus 2 additional clients (#5 and #8), the facility failed to ensure the clients were offered condiments during meals.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/31/12 from 5:45 AM through 7:50 AM. At 6:50 AM staff #2 prepared scrambled eggs on the kitchen stove and placed the eggs on a plate with a piece of toast. Staff #2 placed the plate on the kitchen counter next to a bowl of cereal with milk already poured in the bowl. At 6:55 AM client #8 came to the kitchen and was handed the bowl of cereal and plate by staff #2. Client #8 was not offered a choice of cereal, scrambled/over easy/boiled eggs, or choice of butter or jelly for her toast. Client #8 was not offered ketchup, salt, pepper, or sweetener for her cereal or other choice of condiment for her breakfast. At 7:05 AM client #3 came to the kitchen and was handed the bowl of cereal and plate by staff #2. Client #3 was not offered a choice of cereal, scrambled/over</p>	W0484	<p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Corrective action for resident(s) found to have been affected Clients are to be offered condiments and choice of breakfast items during their morning meal. This includes salt and pepper, jelly or butter, or any other items they would like with their meals.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence In addition to training the staff responsible for the lack of client choice during the survey observation, all staff will be retrained on active treatment and client rights by the QDDP.</p> <p>How corrective actions will be monitored to ensure no recurrence The QDDP will ensure all staff are retrained on active treatment and</p>	11/30/2012			

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	<p>easy/boiled eggs, or choice of butter or jelly for her toast. Client #3 was not offered ketchup, salt, pepper, or sweetener for her cereal or other choice of condiment for her breakfast. At 7:08 AM client #5 came to the kitchen and was handed the bowl of cereal and plate by staff #5. Client #5 was not offered a choice of cereal, scrambled/over easy/boiled eggs, or choice of butter or jelly for her toast. Client #5 was not offered ketchup, salt, pepper, or sweetener for her cereal or other choice of condiment for her breakfast.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/31/12 at 8:36 AM indicated clients should be offered choices of cereal or breakfast items during their morning meal.</p> <p>9-3-8(a)</p>		client choice. The records of training will be sent to the Regional Director to review and sign off.		

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W0488	<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. Based on observation, record review and interview for 2 additional clients (#5 and #6), the facility failed to promote independence during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/31/12 from 5:45 AM through 7:50 AM. At 7:05 AM client #6 came to the kitchen and was handed the bowl of cereal and plate by staff #2. Client #6 was not prompted or encouraged to serve herself or participate in the preparation or plating of her meal. At 7:08 AM client #5 came to the kitchen and was handed the bowl of cereal and plate by staff #5. Client #5 was not prompted or encouraged to serve herself or participate in the preparation or plating of her meal.</p> <p>Client #5's functional skills assessment dated 8/16/12 was reviewed on 11/1/12 at 9:32 AM. Client #5's functional skills assessment indicated, "independent: feeding self, use of utensils, serves self, table manner and can clean up after meals. Verbal prompts; prepare meal."</p> <p>Client #6's functional skills assessment</p>	W0488	<p>The facility must assure that each client eats in a manner consistent with his or her developmental level. Corrective action for resident(s) found to have been affected Clients are to be offered choice and prompted to demonstrate independence consistent with their developmental level during all meals. This includes cooking, gathering supplies, preparing food, and cleaning up consistent with developmental level. How facility will identify other residents potentially affected and what measures taken All residents could be affected and corrective action plan will be put in place to protect all consumers. Measures or systemic changes facility put in place to ensure no recurrence In addition to training the staff responsible for the lack of client choice and promoting independence during the survey observation, all staff will be retrained on active treatment, client rights, and promoting independence by the QDDP. How corrective actions will be monitored to ensure no recurrence The QDDP will ensure all staff are</p>	11/30/2012			

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NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>dated 8/22/12 was reviewed on 11/1/12 at 9:35 AM. Client #6's functional skills assessment indicated, "Verbal prompts: feeds self, uses utensils and table manners. Hand over hand assistance: serve self, prepare meal and clean after meals."</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 10/31/12 at 8:36 AM indicated clients should not be served their meals. QMRP #1 indicated clients #5 and #6 were able to serve themselves with assistance from staff.</p> <p>9-3-8(a)</p>		retrained on active treatment, client choice, and promoting independence. The records of training will be sent to the Regional Director to review and sign off.		

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W9999	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled staff (staff #1) personnel records reviewed, the facility failed to obtain a yearly PPD and/or a chest x-ray and/or PPD screening checklist for employed staff.</p> <p>Findings include:</p> <p>Staff #1's personnel record was reviewed on</p>	W9999	<p>Each staff will submit written evidence that a Mantoux test was completed upon hire and annually thereafter.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Staff #1 received her chest x-ray on 11-5-09. AWS has a policy and annual chest x-ray checklist for physicians to fill out annually before the next chest x-ray is due. The staff is currently on FMLA but will have her next chest x-ray before she returns to work.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The HR Administrative Assistant will forward the Group Home Manager monthly the list of all expiration dates which will include annual chest x-ray checklists. The GHM is responsible to notify all staff of upcoming expiration dates. Staff will be trained that they will be suspended from working if all required tests are not current.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>HR Administrative Assistant will</p>	11/30/2012			

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	<p>10/30/12 at 1:58 PM. Staff #1's record indicated the most recent TB/PPD testing or screening had occurred on 2/11/11. Staff #1's record did not indicate a yearly PPD, chest x-ray or screening checklist had been completed since 2/11/11.</p> <p>Interview with HRC (human resources coordinator) #1 on 10/30/12 at 2:20 PM indicated staff #1 had been on an extended leave of absence and had not completed the annual screening check. When asked the beginning date of staff #1's absence, HRC #1 indicated she would follow up. HRC #1 did not provide a date for staff #1's leave of absence.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 10/31/12 at 8:36 AM. QMRP #1 indicated staff #1 had not been absent since 2/11/12. QMRP #1 stated staff #1 had been on leave, "a few weeks." QMRP #1 indicated staff #1 should have had an annual screening, chest X-ray or PPD annually on 2/11/12.</p> <p>9-3-3(e)</p>		<p>monitor and send to GHM monthly. GHM will monitor and notify staff monthly. The Regional Director will sign off on all records of training showing that staff were trained on expiration dates.</p>		