

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G788		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/12/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 3512 ROSEWOOD DR FORT WAYNE, IN 46804			
(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			
W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: September 9, 10, 11, and 12, 2013.</p> <p>Facility number: 012484 Provider number: 15G788 AIM number: 201011390A</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 26, 2013 by Dotty Walton, QIDP.</p>	W000000					

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G788	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3512 ROSEWOOD DR FORT WAYNE, IN 46804		
(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	
W000368	<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.</p> <p>Based upon record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure medications were passed as indicated in physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 9/9/13 at 4:26 PM. A BDDS report dated 1/20/13 indicated client #4 was given another client's medications of Thorazine (anti-psychotic) 100 mg (milligrams), Zyprexa (anti-psychotic) 15 mg, and omeprazole (Gastroesophageal disorder) 20 mg. The report indicated the nurse assessed the client and notified the primary care physician who recommended staff hold client #4's 7:00 PM Risperdal. The report indicated client #4's neurological signs were monitored and staff was counseled and retrained.</p> <p>The Residential Director was interviewed on 9/11/13 at 4:35 PM. She indicated the staff who administered the medications incorrectly had been retrained, but was unable to pass the training and had been</p>	W000368	<p>This medication error occurred on 1/20/13. The staff member who made the error had been trained in the Indiana required Core A and B curriculum and passed the tests with the required competency. Immediate action was taken which included not allowing this particular staff member to administer medication, re-training of all staff on the AWS Medication Administration policy and requiring this staff person to re-take Core A and B. Upon recertifying, the staffs level of competency of the information provided, did not meet the required score and subsequently, the staff person was terminated from employment with AWS. There have been no further incidents of this type. The manager and QDDP complete regular observations of staff and document those which are reviewed by the director for compliance.</p>	10/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G788	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3512 ROSEWOOD DR FORT WAYNE, IN 46804		
(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	
	terminated.  9-3-6(a)				