

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G734	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2011
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 9726 CINNABAR PL FORT WAYNE, IN46804
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 21, 22, 23, 2011.</p> <p>Facility number: 005567 Provider number: 15G734 AIM number: 200852580</p> <p>Surveyors: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP-Team Leader Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12-8-11 by C. Neary, Program Coordinator.</p>	W0000		
W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 1 sampled client with a stoma who was experiencing diarrhea (client #1), by not ensuring client #1 received nursing services according to his identified medical needs.</p> <p>Findings include:</p>	W0331	<p>The nurse has received training on her requirement of following up on orders to ensure that the staff have implemented them appropriately. She has also received additional training on required documentation including thoroughly documenting size of any injury or area of irritation and vitals necessary for her to appropriately monitor changes or progress to the effected area.</p>	12/23/2011

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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	<p>Observations were conducted in the group home on 11/22/11 from 5:55 AM until 7:15 AM. At 6:40 AM client #1 was observed lying in his bed with a wet 4 x 4 (size of dressing) over the stoma. The skin to the right of the stoma was bright red approximately five inches by five inches. The skin was covered with a white cream. Client #1 was observed to point to the sight and speak, but his words were not understandable. At 6:45 AM on 11/22/11 an interview with staff #1 was conducted. Staff #1 indicated client #1's skin was red when she reported to work on the night of 11/20/11. An interview was conducted with staff #2 at 6:55 AM on 11/22/11 and staff #2 indicated client #1 was in bed due to having diarrhea, they could not get a bag to stay on around the stoma and his skin was irritated from the diarrhea. She indicated he had stayed home from day service yesterday and was staying home also on 11/22/11. She indicated the nurse had seen him 11/21/11. Both staff #1 and #2 indicated client #1's temperature was not being monitored.</p> <p>Client #1's records were reviewed on 11/22/11 at 1:40 PM. Client 1's records contained the following dated documents:</p> <p>03/2011: Skin Risk Protocol with</p>		Spot checks will be completed by the nursing supervisor and/or the residential directors to monitor effotive communication and documentation. All checks will be documented by the supervisor.director initialing the notes reviewed.		

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	<p>Ileostomy Care. The Skin Risk Protocol indicated client #1's skin was to be monitored daily for redness. The protocol did not indicate where the information was to be recorded.</p> <p>11/21/11: Nursing notes indicated the RN had assessed client #1 on 11/21/11. The notes did not contain the time of the assessment. The notes indicated, "Kept home from day program D/T (due to) Diarrhea with surrounding erythema (redness/inflammation) to stoma - unable to adhere bag to surrounding skin. Zinc Oxide to surrounding skin - staff to give Pepto Bismol/Loperamide (diarrhea) prn (as needed) - Breath sounds clear - resp[irations] easy - + (positive for) BS (bowel sounds) - abdomen soft and flat - lower extremities without edema (swelling) or erythema - will monitor response to tx (treatment)." The nursing notes did not contain documentation as to the size of the erythema.</p> <p>11/2011: November 2011 MAR (Medication Administration Record) indicated client #1 had received doses of Pepto Bismol on 11/20/11 at 7:00 PM and 8:00 PM and on 11/21/11 at 1:00 PM, 4:00 PM, 5:00 PM, 6:00 PM, 7:00 PM, 8:00 PM and 9:00 PM. Pepto Bismol was also given to client #1 on 11/22/11 at 1:00 AM and 3:00 AM. The MAR indicated</p>			

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	<p>the Loperamide was given on 11/21/11 twice and 11/22/11 twice. The Loperamide did not indicate the times it was administered. The MAR did not contain any record of recorded temperatures of client #1. The MAR did not contain any information to indicate the skin was being monitored daily.</p> <p>An interview was conducted on 11/22/11 at 2:15 PM with the Registered Nurse (RN). She indicated staff had contacted her on 11/21/11 regarding client #1's diarrhea. She indicated she sent them directions via text message to administer the Pepto Bismol and alternate it with the Loperamide. She indicated the MAR indicated they had not followed her instructions. She further indicated client #1's skin was still irritated and reported to be red. The RN indicated client #1 was not being monitored for a fever and should have been. She also indicated she should have documented the size of the irritated/red area. She indicated she was currently trying to get client #1 seen by the doctor but did not have an appointment scheduled yet.</p> <p>9-3-6(a)</p>				

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W0382	<p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview the facility failed to maintain proper medication security for 1 of 2 sampled clients (client #1), and one additional client (client #4) whose medications included a medication which required refrigeration.</p> <p>Findings include:</p> <p>1. On 11/22/11 from 5:55 AM until 7:15 AM, observations were completed at the group home. At 6:00 AM, client #4 was observed in the medication room with staff #2. Staff #2 was observed to take a vial of medication (Acetylcysteine), draw up the medication from the vial and indicated the medication was for client #4's breathing treatment. At 6:33 AM staff #2 was observed to place the vial on the refrigerator door, in a box with other vials. At 7:01 AM an interview was conducted with staff #2. Staff #2 indicated there were 2 boxes of client #4's medication in the refrigerator. She indicated one box which was unopened contained 25 full vials of the medication. The medication was observed to be in the bottom crisper drawer of the refrigerator. Staff #2 indicated the other box of the</p>	W0382	All staff have been re-trained on the Medication Administration and Storage of Medication policies including their responsibility to secure medications so they are not accessible by other clients in the home. The nurse and management staff are conducting an observation of medication passes with each staff member of the home and will complete spot checks thereafter to ensure that the additional training was effective. This will be documented on a Medication Observation and be submitted to the Residential Director for review and to monitor compliance.	12/23/2011	

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	<p>medication was on the refrigerator door where the eggs normally were held and that box contained 18 vials. She indicated the medications were not locked and this was the manner in which they were kept.</p> <p>An interview was conducted on 11/22/11 at 2:15 PM with the Registered Nurse (RN). She indicated all medications should be locked including refrigerator medications.</p> <p>2. During observation at the group home on 11/21/11 from 4:05 PM until 5:35 PM, client #1's medications of pink bismuth (diarrhea), Gensayne and Simethicone drops (gas) were in a plastic bag stored in a duffle bag unsecured on his dresser.</p> <p>The nurse was interviewed on 11/21/11 at 5:25 PM. She indicated medications should be locked and client #1's medications on his dresser were supposed to be locked at day services.</p> <p>9-3-6(a)</p>				

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W0436	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 2 sampled clients, (client #2), the facility failed to ensure he was encouraged to use his adaptive equipment as per his individual support plan.</p> <p>Findings include:</p> <p>During observation at the group home on 11/21/11 from 4:05 PM until 5:35 PM, client #2 propelled himself in a wheelchair to come to the table for dinner and was not prompted to use a walker to come to the table.</p> <p>Client #2's record was reviewed on 11/21/11 at 11:30 AM. His 2/1/11 Individual Support Plan (ISP) indicated an objective to use his platform walker to go to the dinner table.</p> <p>The Residential Director was interviewed on 11/21/11 at 2:35 PM and indicated client #2 used a wheelchair to come to the dinner table and client #2 should have been encouraged to use a walker to come</p>	W0436	<p>A staff meeting was held and all staff have received additional training on the clients adaptive equipment and the expectation of prompting its use per the ISP. The staff will document its use on ISP data sheets which will be reviewed by the QMRP and progress documented on the Residential Monthly Report which will be monitored by the director to ensure compliance. In home observations will be completed by management staff to ensure that staff are prompting the use of the walker and will be documented on the Dining Observation Checklist and monitored by the director.</p>	12/23/2011			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2011

FORM APPROVED

OMB NO. 0938-0391

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