

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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
W000000	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 7, 8, 9 and 13, 2013.</p> <p>Facility Number: 000596 Provider Number: 15G036 AIMS Number: 100233390</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/21/13 by Ruth Shackelford, 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: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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			
W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to develop a schedule that outlined the clients' current active treatment programs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/8/13 at 12 PM. Client #1's record indicated no active treatment schedule for client #1.</p> <p>Client #2's record was reviewed on 8/8/13 at 2 PM. Client #2's record indicated no active treatment schedule for client #2.</p> <p>Client #3's record was reviewed on 8/8/13 at 1 PM. Client #3's record indicated no active treatment schedule for client #3.</p> <p>Client #4's record was reviewed on 8/9/13 at 11 AM. Client #4's record indicated no active treatment schedule for client #4.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/9/13 at 12:30 PM indicated he was unable to find an active treatment schedule for clients #1, #2, #3 and #4.</p>	W000250	<p>Corrective action for resident(s) found to have been affected Active treatment schedules have been created for each client. Staff will be trained to review these schedules daily to know the individual schedules of each consumer. How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QDDP will be responsible for updating these schedules and placing in the homes. Team Leaders will be responsible for ensuring staff are reviewing and following these schedules. How corrective actions will be monitored to ensure no recurrence Management will review these active treatment schedules monthly when they go to the homes to assure environmental quality. Director will sign off on staff training to use and implement client active treatment schedules.</p>	09/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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	
	The QIDP stated "I think we used to do them, but I can't find them." 9-3-4(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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			
W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure the staff documented the clients' program data as directed.</p> <p>Findings include:</p> <p>Client #1's, #2's, #3's and #4's DS (Data Sheets) for May, June and July 2013 were reviewed on 8/9/13 at 11:30 AM. Client #1's Data Sheets indicated the following objectives and data: ___ Daily to name 2 of his medications. The DS indicated the staff failed to document this objective 8 days in July. ___ Daily client #1 was to brush his teeth for 30 seconds. The DS indicated the staff failed to document this objective 9 days in July, 6 days in June. ___ Daily at breakfast, lunch and dinner client #1 was to eat slowly and take sips of liquids. The DS indicated the staff failed to document this for each meal 18 days in July, 18 days in June and 13 days in May. ___ Daily client #1 was to thoroughly shave his face. The DS indicated the staff failed to document this objective 8 days in July</p>	W000252	<p>Corrective action for resident(s) found to have been affected All staff have been retrained to document objectives at least the number of times warranted by the objective methodology sheet. Team Leaders have been retrained to monitor all documentation to ensure staff are filling out correctly. The nightly task sheet for 3rd shift includes checking documentation to ensure appropriate completion. Night staff will be retrained to complete this task nightly. How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Night staff will monitor all documentation to ensure completion. Team Leaders will check documentation and objective completion weekly as a part of their weekly home audit checklist. Management will check documentation monthly as a part of their monthly environmental checklist. How corrective actions will be monitored to ensure no recurrence Team Leaders will turn the Weekly Home Audit</p>	09/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>and 4 days in June.</p> <p>__ Daily client #1 was to name 2 of his medications and why he took them. The DS indicated the staff failed to document this objective 3 days in June and 10 days in May.</p> <p>Client #2's Data Sheets indicated the following objectives and data:</p> <p>__ AM & PM client #2 was to brush her teeth. The DS indicated the staff failed to document this objective AM and PM 17 days in July, 25 days in June and 15 days in May.</p> <p>__ During breakfast and the evening meal, client #2 was to put her utensil down between bites and alternate between taking a bite and taking a drink. The DS indicated the staff failed to document this objective AM and PM 17 days in July, 23 days in June and 20 days in May.</p> <p>__ Daily client #2 was to be able to shower and/or bathe with hand over hand assistance. The DS indicated the staff failed to document this objective 9 days in July and 8 days in June.</p> <p>__ Five times a week, client #2 was to identify the hot water. The DS indicated the staff failed to document this objective 5 times a week 2 out of 4 weeks in July and 1 out of 4 weeks in June.</p> <p>__ Two times a week client #2 was to choose a leisure activity of her choice. The DS indicated the staff failed to</p>		<p>Checklist in to the Group Home Manager weekly. Management will turn the Monthly Home Environmental Checklist (CQA) into the Regional Director monthly. The director will review and sign and forward to AWS Corporate Compliance department.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>document this objective 2 times a week 1 out of 4 weeks in July.</p> <p>__ Two times a week client #2 was to be able to sort coins. The DS indicated the staff failed to document this objective 2 times a week 3 out of 4 weeks in July.</p> <p>__ Once a week client #2 was to assist with making one dinner item. The DS indicated the staff failed to document this objective once a week 3 out of 4 weeks in July.</p> <p>__ Once a week client #2 was to clean her bedroom. The DS indicated the staff failed to document this objective once a week 1 out of 4 weeks in July.</p> <p>__ Every 2 hours during waking hours the staff were to take client #2 to the bathroom. The DS indicated the staff failed to document this objective 16 out of 31 days in July.</p> <p>__ Twice a day, client #2 was to repeat the names of her medications. The DS indicated the staff failed to document this objective twice a day 25 days in June and 19 days in May.</p> <p>Client #3's Data Sheets indicated the following objectives and data: __ Daily in the AM and PM client #3 was to name two of his medications and tell the staff why he took them. The DS indicated the staff failed to document this objective twice a day 17 days in July, 24 days in June and 24 days in May</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>__Daily client #3 was to wash his hands. The DS indicated the staff failed to document this objective 9 days in July, 8 days in June,</p> <p>__Daily in the AM and PM, client #3 was to brush his teeth for 30 seconds. The DS indicated the staff failed to document this objective AM and PM 19 days in July, 24 days in June and 8 days in May.</p> <p>__Daily client #3 was to complete the steps in taking a bath/shower. The DS indicated the staff failed to document this objective 9 days in July, 9 days in June</p> <p>__Daily client #3 was to change his bedding. The DS indicated the staff failed to document this objective 9 days in July, 9 days in June,</p> <p>Client #4's Data Sheets indicated the following objectives and data:</p> <p>__Daily in the AM and PM client #4 was to be able to tell the staff what medications she was taking. The DS indicated the staff failed to document this objective in the AM and the PM 18 days in July and 17 days in May.</p> <p>__Daily client #4 was to be able to put her dirty clothes in her hamper daily. The DS indicated the staff failed to document this objective 8 days in July.</p> <p>__Daily client #4 was to be able to wash her hair. The DS indicated the staff failed to document this objective 7 days in July.</p> <p>__Daily client #4 was to be able to wash</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>her gums daily using swabs and salt water. The DS indicated the staff failed to document this objective in the AM and the PM 18 days in July and 15 days in May.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/9/13 at 12:30 PM indicated the staff were to document the clients' objectives daily and/or as indicated on the DS. The QIDP indicated the staff failed to document the clients' data the first 2 weeks in July.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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			
W000312	<p>483.450(e)(2) DRUG USAGE</p> <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. Based on record review and interview for 4 of 4 sampled clients receiving medications to control behaviors (#1, #2, #3 and #4), the facility failed to ensure a specific plan of reduction was in place to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/8/13 at 12 PM. Client #1's 2013 physician's orders indicated client #1 took Zyprexa 20 mg (milligrams) a day for behavior modification. Client #1's BSP (Behavior Support Plan) of 9/28/12 indicated client #1 had targeted behaviors of physical aggression, agitation, socially intrusive behaviors, noncompliance and property destruction. The BSP indicated a medication reduction plan for the Zyprexa to be "If [client #1] continues to show progress in his replacement behavior objective and if there is a reduction in psychiatric symptoms, the team will consider a reduction in psychotropic</p>	W000312	<p>Corrective action for resident(s) found to have been affected The Behavior Clinician that was previously working at this home is no longer contracted with AWS. A temporary BC has been contracted from corporate office who will be revising BSPs to include consumer specific titration plans. AWS is currently recruiting for a permanent behavior specialist to monitor the behavior plans of this home. 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. Measures or systemic changes facility put in place to ensure no recurrence The temporary BC is supervised by Dr. Jim Wiltz of AWS. The new behavior specialist will be mentored by Dr. Wiltz who will provide oversight and will sign off on all BSPs. How corrective actions will be monitored to ensure no recurrence BSPs will be written and revised by a BC employed by AWS. Dr. Wiltz will provide mentoring and sign off on all BSPs. The QDDP will</p>	09/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>medication at least annually. The overall plan would be to have [client #1] on the least amount of psychotropic medication while allowing him the greatest level of participation in his life. This should always be balanced with a risk versus benefit assessment of his overall med regimen. The pros and cons of a medication reduction should be discussed at [client #1's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the prescribing physician at each follow-up appointment for a decision to be made on whether a reduction is appropriate...."</p> <p>Client #2's record was reviewed on 8/8/13 at 2 PM. Client #2's 2013 physician's orders indicated client #2 took Depakote ER 1500 mg, Mellaril 300 mg and Trazodone 50 mg a day for behavior modification. Client #2's updated BSP of 11/5/12 indicated client #2 had targeted behaviors of physical aggression and incontinence. The BSP indicated a medication reduction plan for the Mellaril to be "If [client #2] continues to show progress in her replacement behavior objective and if there is a reduction in incidents of physical aggression for a consistent period of time (approximately six months), the team will consider a</p>		<p>continue to use the Quarterly Meeting Checklist which encourages the team to discuss behavior support plans, dates and titration plans. The IDT will sign off on this checklist and it will be forwarded to the Director for review and signature.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>reduction in psychotropic medication at least annually. The overall plan would be to have [client #2] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #2's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the psychiatrist at each follow-up appointment for a decision to be made on whether a reduction is appropriate.... Once Mellaril has been successfully discontinued, then a specific plan of reduction for other medications will be determined."</p> <p>Client #3's record was reviewed on 8/8/13 at 1 PM. Client #3's 2013 physician's orders indicated client #3 took Xanax 1 mg and Paxil 30 mg once a day and a Depo-Provera injection of 150 mg every 3 weeks for behavior modification. Client #3's updated BSP of 11/1/12 indicated client #3 had targeted behaviors of obsession, inappropriate sexual behavior and emotional outbursts of crying, hitting the wall or objects with his fists. The BSP indicated a medication reduction plan for the Paxil to be "If [client #3] continues to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>show progress in his replacement behavior objective and if there is a reduction in the symptoms of anxiety and obsessive behavior, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #3] on the least amount of psychotropic medication while allowing him the greatest level of participation in his life. This should always be balanced with a risk versus benefit assessment of his overall med regimen. The pros and cons of a medication reduction should be discussed at [client #3's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the psychiatrist at each follow-up appointment for a decision to be made on whether a reduction is appropriate.... If [client #3] has a significant decrease in incidents of sexual inappropriateness for a period of more than six consecutive months then a reduction in his Depo-Provera should be discussed with the team and the psychiatrist."</p> <p>Client #4's record was reviewed on 8/9/13 at 11 AM. Client #4's updated BSP of 11/20/12 indicated client #4 had targeted behaviors of verbal/physical aggression, stealing, re-wearing dirty clothes, refusal to follow dietary guidelines, poor</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>boundaries and psychotic symptoms of auditory/visual hallucinations with marked confusion. Client #4's BSP indicated client #4 was taking Lexapro 20 mg four times a day, Lorazepam 1 mg twice a day and Risperdal 1 mg twice a day. Client #4's 2013 physician's orders indicated client #4 took Abilify 2 mg (milligrams) a day and Celexa 10 mg a day for behavior modification. Client #4's physician's orders indicated client #4 did not take Lexapro, Lorazepam and Risperdal. Client #4's BSP failed to include the use of Abilify and Celexa and/or a plan of reduction to reduce and/or eliminate client #4's behaviors in regard to the use of Abilify and Celexa."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/9/13 at 2 PM indicated client #1's, #2's and #3's BSPs included the same titration criteria and were not specific to the clients' behaviors for which each psychoactive medication was to target. The QIDP stated "I think [name of behavior specialist] updated [client #4's] plan [BSP] before he left." The QIDP did not provide an updated copy of client #4's BSP for review.</p> <p>9-3-5(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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			
W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the client's physician conducted an annual physical exam.</p> <p>Findings Include:</p> <p>Client #1's record was reviewed on 8/8/13 at 12 PM. The client's record indicated diagnoses of, but not limited to, bilateral hearing loss, seasonal allergies, high cholesterol, Gout (a form of acute arthritis), Iron Deficiency Anemia and Thrombocytopenia (a blood disease). Client #1's record indicated the client's physician last conducted a physical examination 6/1/12.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/8/13 at 2 PM indicated she had overlooked scheduling client #1's annual physical with client 1's physician. The LPN indicated client #1's last physical exam was conducted 6/1/12 and client #1 was overdue in having his annual physical.</p> <p>9-3-6(a)</p>	W000322	<p>Corrective action for resident(s) found to have been affected Client #1's previous physical was dated 6/1/12. The mother of client #1 took client #1 to the PCP on 4/19/13 for annual physical. While there the mother requested the PCP fill out a physical for Special Olympics. Because of this request the PCP would not bill the visit as an annual physical, only an extended visit. PCP was contacted about error but would not rescheduled annual visit until 8/29/13. Client #1 will be seen for annual physical on 8/29/13. How facility will identify other residents potentially affected and what measures taken Annual exams are current for other residents. Measures or systemic changes facility put in place to ensure no recurrence LPN monitors annual exam dates on a continuous basis. QDDP monitors annual exam dates on a monthly basis via the monthly summary report. IDT monitors annual exam dates at each quarterly meeting. How corrective actions will be monitored to ensure no recurrence IDT will continue to fill out quarterly client meeting checklist which includes dates of annual exams. This checklist is forwarded to Regional Director for review and signature.</p>	09/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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	
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the client's hearing was evaluated annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/8/13 at 12 PM. The client's record indicated a diagnosis of, but not limited to, bilateral hearing loss. Client #1's record indicated a hearing evaluation of 6/7/12.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/8/13 at 2 PM indicated client #1's last hearing evaluation was conducted 6/7/12.</p> <p>9-3-6(a)</p>	W000323	<p>Corrective action for resident(s) found to have been affected Client #1 was seen for annual exam by ENT on 3/12/13. At that time ENT determined that no hearing test was needed and scheduled next annual visit for March 2014 at which time a hearing test would be conducted. LPN has contacted doctors office to request hearing test or documentation from ENT stating the reason hearing test has not been completed. How facility will identify other residents potentially affected and what measures taken Annual exams are current for all other residents. Measures or systemic changes facility put in place to ensure no recurrence LPN monitors annual exam dates on a continuous basis. QDDP monitors annual exam dates on a monthly basis via the monthly summary report. IDT monitors annual exam dates at each quarterly meeting. How corrective actions will be monitored to ensure no recurrence IDT will continue to fill out quarterly client meeting checklist which includes dates of annual exams. This checklist is forwarded to Regional Director for review and signature.</p>	09/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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			
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 sample clients (#4) and 1 additional client (#5), the facility nurse failed to ensure the clients' medications were labeled and all outdated medications were discarded.</p> <p>Findings include:</p> <p>Observations were conducted of the evening medication pass at the group home on 8/7/13 between 4 PM and 4:20 PM. At 4:10 PM staff #4 applied Vaseline to client #4's lips. The tube of Vaseline and the bag it was in was not labeled with the client's name, name of medication, dosage and/or the times to be administered.</p> <p>Observations were conducted of the morning medication pass at the group home on 8/8/13 between 6:25 AM and 8:45 AM.</p> <p>__At 7:10 AM staff #4 gave client #5 a small tube of Vaseline for his lips. The label on the medication bottle the tube of Vaseline was removed from was dated 7/13/12. The tube of Vaseline was not labeled with the client's name, name of medication, dosage and/or times it was to be administered.</p>	W000331	<p>Corrective action for resident(s) found to have been affected Staff will receive retraining to turn in all medicine to the LPN once a new medication has been received by the home. The old bottles have been discarded and new medications have been placed in the home. How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Team Leaders will conduct a weekly medication audit in the home to ensure all medications are present and dated correctly. Team Leaders will also ensure any expired or old medications are turned into the LPN when new medications arrive in the home. How corrective actions will be monitored to ensure no recurrence The LPN will monitor all weekly medication audits to ensure compliance. The LPN is able to go into any group home at any time and does complete random pop in visits to audit medications and ensure compliance. The Regional Director will sign off on staff retraining on medication expiration dates.</p>	09/12/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>__ At 8:35 AM staff #4 placed a small amount of Desonide lotion onto client #4's hand for client #4 to apply to her face. The label on the bottle of Desonide indicated the bottle was received from the pharmacy 7/19/12. The bottle did not indicate an expiration date.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/8/13 at 9 AM indicated all medications were to have a pharmacy label with the client's name, the name of the medication, dosage and time the medication was to be given. The LPN stated any medications dating over a year from the pharmacy "should have been thrown away" and the staff "should have notified me [the LPN]" so the clients' medications could be reordered and/or a new label applied.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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	
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>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, the facility failed to administer prescribed medications per the physician's orders to 3 of 4 sample clients (#2, #3 and #4) and 3 additional clients (#6, #7 and #8).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 8/7/13 at 12:30 PM.</p> <p>The 9/7/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/6/12 at 3 PM during a weekly med audit it was discovered client #2 did not receive 2 doses of her nightly Trazodone 50 mg (for sleep). "Although on the MAR (Medication Administration Record) it was documented that the meds were given there were two pills left over." The report indicated the staff would be retrained.</p> <p>The 10/1/12 BDDS report indicated on 10/1/12 client #6 was given her PRN (as needed) dose of Xanax 0.25 mg instead of her daily dose of extended release. The report indicated the staff would be retrained.</p>	W000368	<p>Corrective action for resident(s) found to have been affected Staff have been retrained on medication administration. Also staff have been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be trained again on the Preventing Medication Errors handout and on the updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly. How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination</p>	09/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>The 11/10/12 report indicated on 11/10/12 at 10 PM "During a controlled medications count it was discovered that one of [client #3's] Lorazepam (for anxiety) .5 mg was missing from the pill pack." The report indicated an investigation was conducted.</p> <p>The 12/16/12 BDDS report indicated on 12/15/12 "it was discovered that [client #7] had not been given his Spiriva 18 mcg (micrograms) since 12/10. This medication is for the treatment of emphysema." The report indicated the last staff to administer the medication failed to contact the nurse so that the medication could be reordered. The report indicated the staff would be retrained.</p> <p>The 12/29/12 BDDS report indicated on 12/29/12 during the morning med pass, client #6 was not given her ER (Extended Release) Xanax. The report indicated the staff would be retrained.</p> <p>The 2/16/13 BDDS report indicated on 2/16/13 at 12 PM client #6 was given her 4 PM dose of Singulair (for asthma) and Calcium. The report indicated the staff would be retrained.</p> <p>The 3/29/13 BDDS report indicated on 3/28/13 during the 8 AM med pass, client #6 was not given her Chlorhexidine</p>		<p>after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration. How corrective actions will be monitored to ensure no recurrence 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. The Regional Director will ensure staff receive this retraining and will sign off on all Record of Trainings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>mouthwash because she was out. The report indicated instead the staff administered her over the counter [name of mouthwash]. "Staff failed to report this error..." The report indicated the staff would be retrained.</p> <p>The 4/1/13 BDDS report indicated on 3/31/13 at 8 AM during the end of the month changeover of medications "It was discovered that [client #4] was only given 1 Entocort 3 mg instead of the prescribed 3 pills on 3/28 and 3/29. This medication is for the treatment of Celiac Disease (a disease of the digestive system)." The report indicated the staff would be retrained.</p> <p>The 5/29/13 BDDS report indicated on 5/29/13 at 7:15 PM client #2 was given her 9 PM dose of Trazodone (antidepressant). The report indicated the staff would be retrained.</p> <p>The 6/3/13 BDDS report indicated on 6/2/13 at 8 PM client #8 was not given his Mineral Oil for constipation. The report indicated the staff would be retrained.</p> <p>The 6/6/13 BDDS report indicated client #2 did not get her 6/5/13 8 PM dose and her 6/6/13 7 AM dose of Chlorhexidine for gingivitis due to running out. The report indicated the staff would be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>retrained.</p> <p>The 7/2/13 BDDS report indicated on 7/2/13 at 7 AM client #7 was given two doses of his Zyprexa (for schizophrenia) 5 mg (milligrams). The report indicated the staff responsible would be retrained.</p> <p>The 7/21/13 BDDS report indicated on 7/21/13 client #6 was given both her .5 mg dose of Xanax (for anxiety) which was discontinued on 7/18/13 and her .25 dose of Xanax which client #6 was currently prescribed. The report indicated "The medication that was discontinued was cleared (sic) marked discontinued do not use but the staff person ignored those directions. That medication was also discontinued on the med administration record which the staff person did not follow." The report indicated the staff would be retrained.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/8/13 at 2 PM indicated all medications were to be given as prescribed by the client's physician. The LPN indicated the staff were retrained after the discovery of each medication error.</p> <p>9-3-6(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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	
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 3 of 75 medications observed being administered, the facility failed to ensure all medications were administered without error to clients #2, #4 and #8.</p> <p>Findings include:</p> <p>Observations were conducted of the morning medication pass at the group home on 8/8/13 between 6:25 AM and 8:45 AM.</p> <p>__At 6 AM client #8 ate cereal with milk, toast and apple juice.</p> <p>__At 7 AM client #2 ate eggs, cereal with milk, toast and juice.</p> <p>__At 7:15 AM client #4 ate a bowl of oatmeal with milk.</p> <p>__At 6:35 AM staff #4 gave client #8 Prilosec (given to reduce stomach acid) 20 mg (milligrams). The pharmacy orders on the bubble package of Prilosec indicated the medication was to be taken before food and/or a meal.</p> <p>__At 8:15 AM staff #4 gave client #2 Prilosec 20 mg. The pharmacy orders on the bubble package of Prilosec indicated</p>	W000369	<p>Corrective action for resident(s) found to have been affected Staff have been retrained on medication administration. Also staff have been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be retrained on the Preventing Medication Errors handout and updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly. How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination</p>	09/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>the medication was to be taken before food and/or a meal.</p> <p>__At 8:35 AM staff #4 gave client #4 Megestrol (a female hormone) 10 ml (milliliter) and Prilosec 20 mg to take orally. Staff #4 then placed a small amount of Desonide lotion onto client #4's hand for client #4 to apply to her face. The pharmacy orders on the bottle of Megestrol and the bottle of Desonide lotion were to shake well prior to using. The pharmacy orders on the bubble package of Prilosec indicated the medication was to be taken before food and/or a meal.</p> <p>Review of client #2's, #4's and #8's August 2013 MARs (Medication Administration Records) on 8/8/13 at 11 AM indicated: __ Clients #2, #4 and #8 were to have Prilosec 20 mg every morning. The MAR did not specify if the medication was to be taken before food and/or a meal. __ Client #4's was to have Megestrol 10 ml and Desonide lotion to her face every AM. The MAR did not indicate "shake well" prior to taking the Megestrol and/or prior to applying the Desonide lotion.</p> <p>Review of client #2's, #4's and #8's physician's orders for July and August 2013 on 8/8/13 at 11:30 AM did not indicate the Prilosec was to be given prior</p>		<p>after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration. How corrective actions will be monitored to ensure no recurrence 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. The Regional Director will ensure staff receive this retraining and will sign off on all Record of Trainings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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>to food and/or a meal. Client #4's orders indicated client #2 was to have Desonide lotion applied to her face twice daily and to receive Megestrol 10 ml every AM.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/8/13 at 9 AM stated the staff were to follow the directives of the physician, the MAR and the pharmacy when passing medications and the staff "should have" ensured clients #2, #4 and #8 received their Prilosec prior to eating their morning meal "not after they ate." The LPN indicated the staff were to follow the pharmacy instructions on the medication bottles, boxes, bags and/or bubble packs.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 820 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	
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8) who resided in the group home, to ensure evacuation drills were conducted at least quarterly for the night shift (11 PM to 7 AM) for the first quarter (January, February and March) of 2013.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 8/8/13 at 11 AM. The review indicated the facility had failed to conduct an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first quarter of 2013 for the night shift.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/9/13 at 12:30 PM indicated the QIDP was unable to find any further drills for review for the first quarter on 2013 for the night's shift of personal.</p> <p>9-3-7(a)</p>	W000440	<p>Corrective action for resident(s) found to have been affected An annual emergency drill calendar has been designed and will be implemented which includes drills on each shift quarterly. Team Leaders will post this annual calendar and mark on the monthly calendar the dates and times drills are due to be completed. How facility will identify other residents potentially affected and what measures taken All residents could potentially be affected and corrective action will address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence An annual emergency drill calendar has been designed and implemented. This annual schedule will include drills to be conducted on each shift quarterly. Team Leaders will post this calendar and mark on the monthly calendar the dates and times drills are to be conducted. How corrective actions will be monitored to ensure no recurrence Staff will be trained to follow emergency drill calendar. Team Leaders will check weekly to ensure drills are being completed as scheduled. Management will check monthly during the environmental quality assessment to ensure drills are</p>	09/12/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 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
			being completed as scheduled. Director will sign off on retraining.	