STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G792	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	9285 W CR 950 N ELIZABETHTOWN, IN 47232

(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	This visit was for a fundamental annual recertification and state licensure survey. Survey dates: March 11, 12 and 13, 2013. Facility number: 012528 Provider number: 15G792 AIM number: 20107060 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/20/13 by Ruth Shackelford, Medical Surveyor III.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview for 1 of 2 clients in the sample (#1), the facility failed to ensure the client had money at the group home in her petty cash account to access. Findings include: A review of client #1's finances at the group home was conducted on 3/11/13 at 4:19 PM. During the past 12 months (March 2012 to March 2013), client #1 had zero money in her account at the group home. There was no documentation at the group home client #1 accessed her money. There was no documentation at the group home indicating the reason client #1 did not have money to access. An interview with staff #3 was conducted on 3/11/13 at 4:19 PM. Staff #3 indicated client #1 had no money in her client petty cash. Staff #3 indicated she was unsure why client #1 did not have money to access. An interview with the Qualified Mental	W000126	**W 126** Client not having Own Funds Available **Corrective action for resident(s) found to have been affected** Group Home Manager coordinates client funds in the house. Manager will receive training to ensure that each month, some of the clients' funds are transferred from the bank – where entitlement funds are deposited – to the home where each client will have individualized access to it. **How facility will identify other residents potentially affected & what measures taken** All residents potentially affected, and corrective measures address the needs of all clients.	04/12/2013

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	Retardation Professional (QMRP) was conducted on 3/12/13 at 11:13 AM. The QMRP indicated client #1 received $30.00 per month. The QMRP indicated she was not aware client #1 did not have money at the home. The QMRP indicated client #1 had a goal to purchase an item with cash or credit three times per month. The QMRP indicated she could not think of a reason why client #1 did not have client funds at the home. The QMRP indicated client #1 had money in her savings account. On 3/13/13 at 11:29 AM, the QMRP indicated the clients should have access to their money at all times. 9-3-2(a)		**Measures or systemic changes facility put in place to ensure no recurrence** Change in procedure to have funds available, and manager training. **How corrective actions will be monitored to ensure no recurrence** The manager coordinates client finances in the home. Each month, summary sheets and receipts are sent to the Director for review. As part of this review, the Director will ensure that some funds are available for client use in the home.	

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 23 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility failed to ensure staff implemented their policies and procedures to prevent client to client abuse and staff to client abuse. Findings include: A review of the facility's incident/investigative reports was conducted on 3/11/13 at 12:15 PM. 1. On 10/6/12 at 12:00 PM, client #1 grabbed client #2 by the shirt and pushed her to the ground. Client #2 was not injured. The investigative report, dated 10/9/12, indicated in the "Were any rights violated?" section, "[Client #2] has the right not to be abused by peers." The facility substantiated peer to peer abuse. 2. On 10/2/12 at 4:30 PM, the former Manager received a call from the former Team Leader (staff #2) with a concern of client safety. Staff #2 received a call from staff #5 regarding former staff #16 using an inappropriate physical contact with client #2. Staff #5 and #6 reported	W000149	**W 149** Protection of Clients from Abuse, especially Peer Abuse **Corrective action for resident(s) found to have been affected** The one instance cited in the survey in which there was abuse by staff involved a client who was engaging in a maladaptive behavior and was restrained inappropriately by a staff member. During the restraint, there also were inappropriate potentially-threatening words spoken by the staff member. Per agency policy, that staff person was suspended, the incident was investigated, and the staff person's job was subsequently terminated after it was determined that the staff person's actions were abusive. Other incidents described involve peer aggression/abuse. In order to address this serious issue, all staff in the home will receive training from a certified Mandt (agency de-escalation and physical intervention technique) instructor. The training will focus	04/12/2013

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	client #2 smacked herself one time across the head to get attention from staff #6. Former staff #16 went behind client #2, put her arms under client #2's and pulled back causing client #2 to lose balance. Client #2 was placed on the floor where former staff #16 kept her there briefly. Former staff #16 told client #2 there was no more hitting herself and this was a time out for her. The investigative report, dated 10/4/12, indicated abuse was substantiated. The report indicated, in part, "[Former staff #16] utilized a restraint that was not approved and while utilizing this restraint she utilized intimidation tactics to gain control over [client #2]. [Former staff #16] wrapped her arms around [client #2's] stomach and lowered her to the floor while stating to her 'you are not going to do that and I will show you what happens when you do that' and then [former staff #16] lowered [client #2] to the floor and stated to [client #2] 'see this is what I am going to do every time you hit yourself, now just sit here and calm down' after about 3 minutes [former staff #16] released the hold and assisted [client #2] off the floor." The report indicated former staff #16 "is being terminated." 3. On 8/3/12 at 10:10 AM, client #4 reached around staff and struck client #3 on the side of her head. Client #3 was not		on appropriate positioning or spacing of staff members when a client or clients are escalated. The express purpose of the training is to be in correct position to prevent peer aggression incidents. **How facility will identify other residents potentially affected & what measures taken** All residents potentially affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** All staff will be trained on appropriate spacing and positioning to prevent future cases of peer aggression. **How corrective actions will be monitored to ensure no recurrence** The home management team is responsible for supervising and training staff. This team is supervised by the Director who meets with them on a regular basis to monitor plan implementation, including training	

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	injured. 4. On 6/5/12 at 11:25 AM, client #1 grabbed client #2 by the shoulders and bit her on the top of her left shoulder leaving a red mark but no broken skin. The investigative report, dated 6/6/12, indicated, in part, "[Client #1] had been agitated earlier and was pacing as is her normal pattern. As she was pacing she walked behind [client #2], grabbed her by the shoulders and bit [client #2] on the top (sic) left shoulder... The bite left a red mark but did not break the skin." The facility indicated the client to client abuse was not substantiated. The report indicated, "The area in question at the day program (facility-operated) is small and had one more client than is typical (4 as opposed to 3). This created a crowded situation which possibly contributed to the incident. [Client #1] also had several teeth extracted two weeks earlier and it is possible there was some lingering discomfort associated with this and again may also have been a contributor to the incident." 5. On 6/2/12 at 7:15 PM, client #1 was struck by a box fan client #4 swung at her. The investigative report, dated 6/4/12, indicated client to client abuse was not substantiated. The report indicated, "The aggressive action occurred and [client #1]		needs of staff members.	

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	was struck by the box fan [client #4] grabbed and swung at her. [Client #4] struggles with mental illness and is diagnosed with Schizoaffective disorder. She is often impulsive and will sometimes respond to internal stimuli in an aggressive way. Her actions during this incident are consistent with this pattern and [client #1] appeared to be a target of convenience as opposed to being specifically targeted by [client #4] and the use of the fan opportunistic. As is often the case the aggression was short lived and 'hit and run' in nature." A review of the facility's Group Home Abuse and Neglect policy, dated 8/08, was conducted on 3/11/13 at 12:06 PM. The policy indicated, in part, "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse. Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Verbal abuse is speaking, writing or gesturing in a derogatory manner to a client or in proximity of a client. Psychological abuse includes doing or saying anything that would humiliate an individual, like teasing or making fun. It includes threats of punishment or deprivation as well as threats or intimidation. Neglect includes			

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	failure to provide appropriate care, food, medical care or supervision. Exploitation includes any deliberate misplacement of individual ' s money, wrongful use of an individual ' s money or belongings. If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place. If the charges are substantiated disciplinary action will be taken which may include termination. Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/12/13 at 11:13 AM. The QMRP indicated client to client aggression was abuse. The QMRP stated the facility staff "We do our best to prohibit." The QMRP indicated there was zero tolerance for staff to client abuse. The QMRP indicated one staff was terminated for inappropriate restraint and verbal abuse. The QMRP indicated the staff should prevent client to client abuse.			

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	9-3-2(a)			

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W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 2 clients in the sample (#1), the facility failed to ensure her program plan indicated when she was to wear a helmet. Findings include: An observation was conducted at the group home on 3/11/13 from 3:01 PM to 6:01 PM. During the observation, client #1 was wearing a helmet at all times. An observation was conducted at the group home on 3/12/13 from 6:44 AM to 8:47 AM. From 6:44 AM to 8:36 AM, client #1 was not wearing a helmet. At 8:36 AM, client #1 exited her bedroom wearing her helmet. A review of client #1's record was conducted on 3/12/13 at 9:49 AM. Client #1's Risk Summary, dated 10/18/12, indicated client #1 had the potential for falls. The plan indicated, "[Client #1] will drop to the ground when she is upset and may have difficulty especially when out of the home on uneven surfaces. [Client #1] likes to gently bump or bounce into walls when up and moving	W000240	**W 240** Inconsistent Helmet Use **Corrective action for resident(s) found to have been affected** The IDT met and made changes to when the client needs to wear a helmet. These changes will ensure greater safety for the client, and they will be easier to implement consistently by staff members. The risk plan also has been updated. Staff training will be conducted to ensure that staff know how to implement the changes. **How facility will identify other residents potentially affected & what measures taken** This is the only resident who wears a helmet, so the changes are very specific to her. **Measures or systemic changes facility put in place to ensure**	04/12/2013

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	about the house... [Client #1] wears a helmet at all times when out of the home to protect her face and head from injury in the event of a fall. The helmet may be removed while in the home and [client #1] is calm." A Case Conference note, dated 1/22/13, indicated, "Team discussed need to (increase) helmet usage may wear during waking hrs (hours) as needed for unstable gait and bx (behavior)." The Individual Support Plan (ISP), dated 10/1/12, indicated, "[Client #1] requires a helmet and gait belt protocol due to her unsteady gait, fall risk, and history of head banging." The plan indicated, "[Client #1] requires a helmet and gait belt along with a wheelchair for long distances when traveling due to her unsteady gait." An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 3/12/13 at 9:52 AM. The QMRP indicated within the past month, client #1 has had to wear her helmet more often. The QMRP indicated there was an interdisciplinary team meeting to increase the use of the helmet at all times when at home. The QMRP indicated client #1 should be wearing her helmet at all times. The QMRP indicated client #1 should have been wearing her helmet on 3/12/13 during the morning shift due to when the QMRP observed her, client #1 was		**no recurrence** IDT met and made changes to the plan. The nurse has updated the risk plan to reflect the changes. Staff will be trained on changes to ensure they are implemented consistently. **How corrective actions will be monitored to ensure no recurrence** The QDDP and Nurse work together to update treatment plans, including the risk plan. Both are supervised by the Director. They meet on a regular basis.	

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	unsteady. On 3/13/13 at 11:29 AM, the QMRP stated she was "wrong" on 3/12/13 regarding client #1's helmet plan. The QMRP indicated the plan needed to be revised to be more specific including the possibility of a certain time period client #1 would wear her helmet. The QMRP indicated one staff may think client #1 needed to wear her helmet while another staff may not see it the same way. The QMRP stated the plan needed to be "more black and white." 9-3-4(a)			

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W000488	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 and interview for 2 of 2 clients in the sample (#1 and #2) and two additional clients (#3 and #4), the facility failed to ensure the clients participated in meal preparation. Findings include: An observation was conducted at the group home on 3/11/13 from 3:01 PM to 6:01 PM and 3/12/13 from 6:44 AM to 8:47 AM. On 3/11/13 at 3:16 PM, staff #3 stated to client #1 she was "working on her Kool-aid." Staff #3 made the Kool-aid and took the drink to client #1. At 3:34 PM, staff #15 emptied the dishwasher without involving clients #1, #2, #3 and #4. At 4:15 PM, staff #3 asked staff #15 to get client #3 a glass of ice water. Client #3 was not involved in getting her own water. From 5:14 PM to 5:20 PM, staff #15 was in the kitchen making gravy for dinner. Staff #15 stood at the stove and stirred the gravy. None of the clients was prompted to assist. At 5:22 PM, staff #7 used the food processor. Staff #10 asked staff #7 to get client #4 a drink. Staff #15 got the drink for client #4 and gave it to staff #10. Staff #10 gave the water to client #4.	W000488	**W 488** Food Preparation and Family-Style Dining **Corrective action for resident(s) found to have been affected** All staff across the home will be trained on family-style dining and “teachable moments” to ensure that clients are involved in the activities surrounding food preparation, serving, clean up, etc. **How facility will identify other residents potentially affected & what measures taken** All residents potentially affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Staff training will occur.	04/12/2013

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	Client #4 indicated she did not want water. At 5:23 PM, staff #15 put food onto divided plates. Staff #7 hand washed the food processor. At 5:29 PM, staff #15 continued to put food onto plates as clients #1, #2, and #3 sat at the dining room table. Client #4 went to wash her hands. Staff #2 used the food processor to puree client #1's food. Client #1 was not prompted to assist. Staff #10 put paper towels on the table to use as napkins. Staff #2 used the food processor to puree meat and vegetables. Staff #15 used a fork to cut up food on a divided plate. Staff #2 rinsed off the food processor blade. At 5:37 PM, staff #10 gave clients #2 and #4 cheese crackers. At 5:38 PM, staff #10 put bowls and spoons on the table for clients #1 and #3. Staff #10 gave clients #2 and #4 more cheese crackers. At 5:40 PM, staff #7 poured milk into cups and staff #2 used the food processor. At 5:42 PM, staff #7 put Thick It into client #1's cups and stirred. At 5:44 PM, staff #2, #7 and #15 were in the kitchen. None of the clients was in the kitchen. At 5:44 PM, staff #7 put drinks on the table. Staff #15 used the food processor for vegetables. Staff #7 put margarine on bread and cut up the bread. At 5:51 PM, staff #7 and #15 gave clients #1, #2, #3 and #4 their plates with their food on the plates.		**How corrective actions will be monitored to ensure no recurrence** The home management team is responsible for supervising and training staff. This team is supervised by the Director who meets with them on a regular basis to monitor plan implementation, including training needs of staff members.	

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	On 3/12/13 at 6:53 AM, staff #12 emptied the dishwasher with no client involvement. At 7:02 AM, staff #12 indicated to staff #8 the clients' lunches were made. At 7:10 AM, staff #8 got out cereal, milk, juice, bread, toaster and the food processor. Clients #1 and #4 were in the area and available to assist but were not prompted to assist. At 7:11 AM, staff #8 put bread in the toaster. At 7:12 AM, client #1 was asked by staff #8 to choose a cereal. Staff #8 poured the cereal into a measuring cup and then into the food processor. Staff #8 added milk and pureed the cereal and milk. Staff #8 poured the cereal and milk into client #1's divided plate. Staff #8 rinsed the food processor. Staff #11 stated, "This is cute. They are lined up for breakfast." Staff #8 pureed client #1's toast. At 7:16 AM, staff #8 put toast on a divided plate and filled the sink with soapy water. Staff #11 indicated the overnight staff made the clients' lunches. At 7:19 AM, staff #8 took client #1's plate to the table. An interview with staff #11 was conducted on 3/12/13 at 7:59 AM. Staff #11 indicated the overnight staff packed the clients' lunches last night due to the clients going on an outing this morning. An interview with the Qualified Mental Retardation Professional (QMRP) was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G792	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 9285 W CR 950 N ELIZABETHTOWN, IN 47232	

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	conducted on 3/12/13 at 9:28 AM. The QMRP indicated she expected the clients to eat family style with food in serving bowls on the table. The QMRP stated the group home was, "Not a restaurant." The QMRP indicated the clients should be involved in serving themselves and the preparation. The QMRP indicated the clients should pack their own lunches. The QMRP stated, "Always some type of teachable moment." 9-3-8(a)			