

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G804	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/20/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 6904 DRY CREEK CT FORT WAYNE, IN 46835
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 14, 15, 16, 17 and 20, 2012.</p> <p>Facility number: 012624 Provider number: 15G804 AIM number: 201022150</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 2/23/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based upon record review and interview, the facility failed to obtain a legally sanctioned representative for 1 of 4 sampled clients (client #4) assessed as being in need of assistance to assure protection of her rights as a citizen of the United States.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 2/16/12 at 1:45 P.M.. Client #4's records did not include evidence of an identified legally sanctioned representative to assist her in making decisions. Client #4's Individual Support Plan (ISP) dated 11/11/11 included, but was not limited to, the use of psychotropic medications to address her insomnia. Client #4 signed consent for the plan on 11/11/11. Client #4's comprehensive functional assessment (CFA) dated 1/12/11 indicated she was unable to understand the reason for her medications, was unable to know the side effects of her medications, lacked the skills to provide consent for psychotropic medication, and was unable to sign off</p>	W0125	<p>Client #4 has been referred to the Mental Health Association for guardianship services. Documentation of this referral will be placed in the client file. Client #4 does not have any appropriate friends or family to assume this role. If AWS locates an unassociated volunteer who is willing and appropriate, we will pursue that in lieu of the Mental Health Association. Monthly updates will be obtained from the Mental Health Association and AWS staff will inquire about the estimated length of wait. AWS will continue to assess clients for their need of representation and as appropriate will assist in obtaining volunteers and providing financial support to those volunteers and appropriate family members. However, if those resources are unavailable, AWS will continue to refer clients to available community resources. All other clients in the home have been assessed and are appropriately represented. Ongoing compliance will be monitored by the director.</p>	03/21/2012			

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	<p>independently for financial forms, emergency medical treatment, was unable to make safe decisions, and did not understand the concept of rights.</p> <p>The Residential Director was interviewed on 2/20/12 at 3:43 P.M. and indicated client #4 would benefit from receiving assistance in making decisions.</p> <p>9-3-2(a)</p>				

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, the facility failed to provide a quarterly nursing assessment for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 2/16/12 at 1:10 P.M.. There was no evidence in client #3's record to indicate the need for a medical care plan. Client #3's record did not include quarterly nursing assessment between the dates of 7/3/11 to 12/11/11.</p> <p>The Residential Director (RD) was interviewed on 2/20/12 at 3:43 P.M.. When asked about client #3's missing nursing quarterly the RD indicated there were no additional nursing assessments available for review.</p> <p>9-3-6(a)</p>	W0336	<p>All quarterly assessments for the other individuals for October 2011 were present in the files. The nurse indicated that this assessment was completed although paperwork was unable to be located in the file. The nurse has received re-training on the requirments to have an assessment present. File reviews will be completed to monitor ongoing compliance and these reviews will be monitored by the director.</p>	03/21/2012	

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility staff failed to assure insulin injections were administered for 1 of 1 sampled clients requiring insulin injections (client #3) according to his physician's orders.</p> <p>Findings include:</p> <p>Facility records were reviewed on 2/14/12 at 11:50 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 6/30/11 and 2/14/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/21/11 for an incident on 10/20/11 at 5:00 P.M. indicated "On October 20th, [client #3's] blood glucose was checked 30 (thirty) minutes before dinner. [Client #3's] blood glucose level was 178. [Client #3] is administered insulin injections according to a sliding scale documented on (sic) medication administration record MAR). According to (sic) MAR [client #3] was to be given 3 (three) units of insulin. Staff administrating medication gave [client #3] 30 (thirty) units of insulin. Residential manager and residential nurse were notified. Staff implemented corrective measures by giving [client #3] sugar based foods and 8 (eight) ounces of orange juice. [Client #3] remained responsive. Residential nurse stayed with [client #3], monitoring vitals until [client #3's] blood sugar was stable. Staff monitored vitals every hour until 6 A.M. October 21rst. [Client #3's] blood glucose was monitored every hour until 12 A.M. October 21rst. Then it</p>			W0368	<p>This incident occured on 10/20/11. The nurse and physician were notified immediatly and vitals were taken ever hour for the fist 24 hours and then every four hours until the next morning. All staff received retraining on the AWS Medication Administration Policy and the Insulin Administration Policy at that time. The staff who made the error was suspended from passing medications and re-took Core A and B medication administration classes. Once those were complete, the staff person observed medication passes and then was observed by the nurse passing medication to ensure understanding of the physicians order and the policies. All medication errors are reviewed by the director so that training needs can be identified and measures put in place to reduce errors. This staff has had no medication errors since this error.</p>		03/21/2012

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	<p>was monitored every four hours until 6 A.M...."</p> <p>Client #3's record was reviewed on 2/16/12 at 1:10 P.M.. Client #3's Physician's Order (PO) signed and dated by his physician on 1/1/12 indicated client #3 had a diagnosis of, but not limited to, Insulin Dependent Diabetes Mellitus. Client #3 was prescribed Actos (diabetes) 15 mg (milligrams) 1 tablet daily, Metformin HCL (diabetes) 1,000 mg 1 tablet two times a day with meals, and Novolog 100 units/ML vial inject sub-q (subcutaneous) per sliding scale 121-150 = 1 unit, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 9 units, 351-400 = 11 units, 401-450 = 13 units, 451-500 =15 units, 501-550 = 17 units.</p> <p>The Residential Director (RD) was interviewed on 2/20/12 at 3:43 P.M.. When asked about the medication error of too much insulin being given to client #3 The RD stated, "It was a significant event."</p> <p>9-3-6(a)</p>				