

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/08/2012
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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W0000	<p>This visit was for the investigation of complaint #IN00112856.</p> <p>COMPLAINT #IN00112856, SUBSTANTIATED: Federal/State deficiencies related to the allegation(s) are cited at W285 and W304.</p> <p>Dates of Survey: August 7 and 8, 2012.</p> <p>Facility number: 012371 Provider number: 15G764 AIM number: 200986870</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 completed August 17, 2012 by Dotty Walton, 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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W0285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on record review and interview, the facility failed to ensure behavioral interventions were implemented with sufficient safeguards by direct contact staff/DCS to prevent injury (fractured clavicle) for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/8/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports since 7/1/12. The reports indicated the following:</p> <p>A BDDS report dated 7/20/12 for an incident on 7/19/12 at 3:30 P.M. indicated, "On 7/19/12 [client A] went to the [name of fitness center] with staff and peers. [Client A] and [DCS #1] were walking from the lobby area to enter the [fitness center] when [client A] started cussing and yelling and struck [DCS #1] on the left side of his face. [DCS #1] attempted to restrain [client A] and move him away from people in this area when</p>	W0285	All staff have received additional training on client A's Behavior Support Plan (BSP). Additionally the plan has been revised to add the use of a Side Body Hug, which is a Mandt and AWS approved physical technique. It is believed that this technique, if needed due to imminent harm or danger, will provide client A with additional support should he throw himself to the ground and allow staff to support him properly. All staff have also received retraining in Technical Mandt. This training was conducted by the director who is responsible to review any use of restraints on an ongoing basis. Staff have also received additional training on BDDS reporting requirements including the use of restraints and additional training to notify their supervisor of any falls so that a fall protocol may be initiated as needed. Post tests were administered to the staff to ensure their understanding and were reviewed by the Residential Director.	09/07/2012	

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	<p>[client A] and [DCS #1] fell to the floor. [Client A] landed on his left shoulder on the floor of the [fitness center] lobby. [DCS #1] then stated he (DCS #1) hovered over him (client A) with his legs on both sides of [client A's] waist. [DCS #1] stated that he held [client A's] right arm with his right hand while he used his left hand to get his phone to call another staff who was at the [fitness center]. The [fitness center] staff came and offered assistance to [DCS #1] but an additional AWS staff returned to the lobby and [client A] left. [Client A] did not complain of any pain throughout the evening but when assessed by the nurse on the morning of 7/20/12 a bruise was noticed along the shoulder. [Client A] was taken to the emergency room and was diagnosed with a broken clavicle...."</p> <p>Emergency Room discharge paperwork dated 7/20/12 was reviewed on 8/8/12 at 4:26 P.M. and indicated "There is an oblique fracture through the distal 3rd (third) clavicle with mild displacement. The fracture extends to the expected site of the coracoclavicular ligament. The fracture does not appear to extend to the AC (acromioclavicular) joint, which retains normal alignment." The ER doctor consulted with [name of local orthopedic center]. Client A was discharged back to the group home with a left arm/shoulder</p>				

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	<p>sling. The sling was to be removed every six hours for range of motion to "prevent frozen shoulder." Client A was to follow-up with the orthopedic physician in two weeks.</p> <p>Facility investigation documentation for the incident on 7/19/12 was reviewed on 8/8/12 at 3:12 P.M. The investigation documentation indicated the following:</p> <p>DCS #1's statement dated 7/20/12 indicated "...he (client A) hit me above my left eyebrow. I proceeded to place my hand on his arm area to turn and guide him to the ground. [Client A] was already going to the ground on his own. [Client A] was on the ground, he's yelling and using verbal aggression. I was afraid that he would endanger someone so I hovered over him by legs on each of his sides. I was over him but I wasn't putting my weight on him, he could still move his arms...."</p> <p>Client A's statement dated 7/20/12 at 10:00 A.M. was written by the Residential Director (RD) as stated by client A. "[Client A] said that he hit [DCS #1] in the eye and then [DCS #1] tried to get him (client A) to stop hitting and [DCS #1] and [client A] fell to the floor. [Client A] then said that [DCS #1] was sitting on him (client A) until he was</p>						

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	<p>calm...He (client A) reported his shoulder did not hurt until he woke up on Friday 7/20/12 when he got to the workshop. He then called the nurse to come and look at it."</p> <p>Client E's statement dated 7/22/12 was written by the RD as stated by client E. "I saw [client A] on the ground with staff person [DCS #1] sitting on him. [Client A] was still moving and yelling."</p> <p>The Conclusion of the Investigation form dated 7/23/12 was reviewed on 8/8/12 at 3:12 P.M. it indicated "... It was determined through [DCS #1's] statement and staff statements that [DCS #1] failed to report the incident of restraint/fall of [client A] and further implemented an unauthorized restraint...[DCS #1] will be terminated for failure to report the fall and restraint to his supervisor...."</p> <p>Client A's Behavior Support Plan (BSP) dated 6/18/12 was reviewed on 8/8/12 at 3:53 P.M. Client A's BSP included the use of MANDT blocking techniques (agency approved/taught system used to counter physical aggression safely). Client A's BSP did not include the use of restraint.</p> <p>The RD was interviewed on 8/8/12 at 2:58 P.M. When asked what physical</p>						

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	<p>intervention was to be used with client A the RD stated, "Blocking is to be used per his BSP." When asked to describe MANDT blocking techniques the RD stated, "Not grabbing or hands on." When asked about the technique DCS #1 had used with client A the RD stated, "Obviously a technique we do not use." The RD indicated DCS #1 was terminated for using an unauthorized restraint and for failure to report the restraint/fall to his supervisor."</p> <p>This Federal tag relates to complaint #IN00112856.</p> <p>9-3-5(a)</p>				

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W0304	<p>483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client. Based on record review and interview, the facility failed to ensure direct care staff (DCS) did not perform an unauthorized physical intervention for 1 of 4 sampled clients (client A), which caused injury to client A (fractured clavicle).</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/8/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports since 7/1/12. The reports indicated the following:</p> <p>A BDDS report dated 7/20/12 for an incident on 7/19/12 at 3:30 P.M. indicated, "On 7/19/12 [client A] went to the [name of fitness center] with staff and peers. [Client A] and [DCS #1] were walking from the lobby area to enter the [fitness center] when [client A] started cussing and yelling and struck [DCS #1] on the left side of his face. [DCS #1] attempted to restrain [client A] and move him away from people in this area when [client A] and [DCS #1] fell to the floor. [Client A] landed on his left shoulder on the floor of the [fitness center] lobby. [DCS #1] then stated he (DCS #1) hovered over him (client A) with his legs</p>	W0304	All staff have received additional training on client A's Behavior Support Plan (BSP). Additionally the plan has been revised to add the use of a Side Body Hug, which is a Mandt and AWS approved physical technique. It is believed that this technique, if needed due to imminent harm or danger, will provide client A with additional support should he throw himself to the ground and allow staff to support him properly. All staff have also received retraining in Technical Mandt. This training was conducted by the director who is responsible to review any use of restraints on an ongoing basis. Staff have also received additional training on BDDS reporting requirements including the use of restraints and additional training to notify their supervisor of any falls so that a fall protocol may be initiated as needed. Post tests were administered to the staff to ensure their understanding and were reviewed by the Residential Director.	09/07/2012			

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	<p>on both sides of [client A's] waist. [DCS #1] stated that he held [client A's] right arm with his right hand while he used his left hand to get his phone to call another staff who was at the [fitness center]. The [fitness center] staff came and offered assistance to [DCS #1] but an additional AWS staff returned to the lobby and [client A] left. [Client A] did not complain of any pain throughout the evening but when assessed by the nurse on the morning of 7/20/12 a bruise was noticed along the shoulder. [Client A] was taken to the emergency room and was diagnosed with a broken clavicle...."</p> <p>Emergency Room discharge paperwork dated 7/20/12 was reviewed on 8/8/12 at 4:26 P.M. and indicated "There is an oblique fracture through the distal 3rd (third) clavicle with mild displacement. The fracture extends to the expected site of the coracoclavicular ligament. The fracture does not appear to extend to the AC (acromioclavicular) joint, which retains normal alignment." The ER doctor consulted with [name of local orthopedic center]. Client A was discharged back to the group home with a left arm/shoulder sling. The sling was to be removed every six hours for range of motion to "prevent frozen shoulder." Client A was to follow-up with the orthopedic physician in two weeks.</p>						

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	<p>Facility investigation documentation for the incident on 7/19/12 was reviewed on 8/8/12 at 3:12 P.M. The investigation documentation indicated the following:</p> <p>DCS #1's statement dated 7/20/12 indicated "...he (client A) hit me above my left eyebrow. I proceeded to place my hand on his arm area to turn and guide him to the ground. [Client A] was already going to the ground on his own. [Client A] was on the ground, he's yelling and using verbal aggression. I was afraid that he would endanger someone so I hovered over him by legs on each of his sides. I was over him but I wasn't putting my weight on him, he could still move his arms...."</p> <p>Client A's statement dated 7/20/12 at 10:00 A.M. was written by the Residential Director (RD) as stated by client A. "[Client A] said that he hit [DCS #1] in the eye and then [DCS #1] tried to get him (client A) to stop hitting and [DCS #1] and [client A] fell to the floor. [Client A] then said that [DCS #1] was sitting on him (client A) until he was calm...He (client A) reported his shoulder did not hurt until he woke up on Friday 7/20/12 when he got to the workshop. He then called the nurse to come and look at it."</p>				

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	<p>Client E's statement dated 7/22/12 was written by the RD as stated by client E. "I saw [client A] on the ground with staff person [DCS #1] sitting on him. [Client A] was still moving and yelling."</p> <p>The Conclusion of the Investigation form dated 7/23/12 was reviewed on 8/8/12 at 3:12 P.M. it indicated "... It was determined through [DCS #1's] statement and staff statements that [DCS #1] failed to report the incident of restraint/fall of [client A] and further implemented an unauthorized restraint...[DCS #1] will be terminated for failure to report the fall and restraint to his supervisor...."</p> <p>Client A's Behavior Support Plan (BSP) dated 6/18/12 was reviewed on 8/8/12 at 3:53 P.M. Client A's BSP included the use of MANDT (agency approved/taught system used to counter physical aggression safely) blocking techniques. Client A's BSP did not include the use of restraint.</p> <p>The RD was interviewed on 8/8/12 at 2:58 P.M. When asked what physical intervention was to be used with client A the RD stated, "Blocking is to be used per his BSP." When asked to describe MANDT blocking techniques the RD stated, "Not grabbing or hands on." When</p>				

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	<p>asked about the technique DCS #1 had used with client A the RD stated, "Obviously a technique we do not use." The RD indicated DCS #1 was terminated for using an unauthorized restraint and for failure to report the restraint/fall to his supervisor."</p> <p>This Federal tag relates to complaint #IN00112856.</p> <p>9-3-5(a)</p>			