

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G796		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 6856 WHEELLOCK RD 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: January 17, 18, 19, 2012.</p> <p>Facility number: 012549 Provider number: 15G796 AIM number: 201019420</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/27/12 by Ruth Shackelford, 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>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 3 of 4 sampled clients (clients #1, #2 and #3) assessed as being in need of assistance to assure their protection of rights as a citizen of the United States.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/18/12 at 1:28 PM. Client #1's records did not include evidence of an identified legally sanctioned representative to assist her in making decisions. Client #1's Behavior Support Plan (BSP) dated 10/31/11 included the use of psychotropic medication to address her behavior. Client #1 signed consent for the plan (undated). Client #1's comprehensive functional assessment (CFA) dated 10/11/11 indicated she was unable to understand the purpose or side effects of her medication, needed assistance to manage her finances, and was not able to understand her civil rights.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on</p>	W0125	<p>Client #1 has been referred to the Mental Health Association for guardianship services. Documentation of this referral will be placed in the client file. Client #1 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. Client #3 had preciously been referred to the Mental Health Association in May 2011. Client #3 was placed on the waiting list at that time. Client #3 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 has obtained an unassociated volunteer who is willing and appropriate to assume guardianship for client #2. A referral has been made to a</p>	02/18/2012			

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	<p>1/18/12 at 1:24 PM and indicated client #1 was in need of assistance in making decisions and a referral had been made to secure a legally sanctioned representative.</p> <p>2. Client #2's record was reviewed on 1/18/12 at 12:16 PM. Client #2's record indicated a signed agreement by a person who was in the process of obtaining status of health care representative (HCR) to provide advocacy for client #2. There was no documentation of client #2's agreement of the assignment of a HCR to assist him in making decisions. Client #2's BSP dated 11/1/11 included the use of psychotropic medication to address his behaviors and was signed by client #2 and by the person who was in the process of obtaining HCR status. Client #2's CFA dated 10/2011 indicated he was unable to understand the purpose or side effects of medication. There was no further documentation or evidence of due process to ensure a legally sanctioned representative to assist client #2 in making decisions.</p> <p>The QDDP was interviewed on 1/18/12 at 1:24 PM and indicated client #2 was in need of a legal representative, but currently was not assigned a representative though a person was in process of becoming his HCR.</p>		<p>lawyer, Solomon Lowenstein who will petition the court and represent the volunteer throughout the proceedings. AWS will provide financial support to the volunteer so guardianship can be obtained. Due to the nature of the courts, AWS is unable to verify when this will be complete but confirmation of contact will be placed in the clients file for review. 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.</p>				

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	<p>3. Client #3's record was reviewed on 1/19/12 at 12:25 PM. Client #3's record indicated he had been referred for guardianship in 5/11 and a letter in response indicated client #3 was placed on a waiting list. Client #3's behavior plan dated 5/17/11 included the use of psychotropic medication to address his behavior, and a physician's order dated 12/28/11 indicated he had been prescribed medication to treat headaches. Client #3's December, 2011 MAR (medication administration record) indicated he had been given the psychotropic medication prior to a medical procedure on 12/20/11. Client #3's CFA dated 10/15/11 indicated he was unable to understand the purpose or side effects of medication and was in need of assistance to manage his finances. There was no evidence of signed approval for the behavior plan, use of medication to treat headaches and no evidence client #3 had a legally authorized representative available to sign consent for the use of medication to treat his behavior and headaches.</p> <p>The QDDP was interviewed on 1/19/12 at 2:00 PM and indicated client #3 was on a waiting list for legal assistance in making decisions and no further action had been taken since 5/11.</p> <p>9-3-2(a)</p>						

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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility neglected to implement their policy and procedures to implement immediate and effective corrective action to protect 3 of 4 sampled clients (clients #1, #2 and #3) and one additional client (client #7) from physical aggression after a pattern of physical aggression had been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/17/12 at 4:10 PM and included the following reports involving discharged client #8:</p> <p>-A report dated 8/6/11 indicated client #8 hit client #7 on his head two times without injury. Corrective action indicated staff would position themselves between client #8 and other clients and staff were trained on ways to prevent aggression.</p> <p>-A report dated 8/8/11 indicated client #8 was admitted to a mental health facility and released on 9/1/11 to evaluate client</p>	W0149	<p>AWS placed client #8 on 7/19/11 at the urgent request from the state. Client #8 became physically aggressive beginning in August and AWS had him assessed by a behavior analyst and the plan was updated immediately and an emergency medication evaluation was scheduled on 8/8/11. At that time, AWS met with BDDS and an agreement was made to seek alternate placement for Client #8 due to his needs. Client #8 was admitted to a local psychiatric facility and remained there until 9/1/11 at which time he was believed to be stable. Additional staff training, staffing and BSP revisions were made regularly throughout this time as AWS waited on approval to move client #8 to an AWS ESN home. Although Client #8 was physically aggressive, AWS staff and their interventions were appropriate and did protect clients from injury. On one occasion, a consumer required basic first aid from staff but all other incidents went without injury. AWS did implement corrective action to protect clients as we waited on the state to approve client #8 for a more appropriate environment including interventions in the BSP, medication evaluation and inpatient medication adjustment, providing staffing above and</p>	02/18/2012			

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	<p>#8 due to "behavioral incidents" with medication adjustments. The report indicated client #8 was being referred to alternate placement.</p> <p>-A report dated 9/15/11 indicated client #1 was hit on the head by client #8 without causing injury. Corrective action included staff being placed between clients and client #8 and training would be provided to staff regarding client #8. No additional corrective action was available to review regarding the incidents or steps to prevent future occurrence.</p> <p>-A report dated 9/25/11 indicated client #8 hit client #1 on the head without causing injury. The report indicated client #8's plan had been implemented and staff redirected him to another area. Corrective action included a plan to change client #8's behavior plan and schedule.</p> <p>-A report dated 9/15/11 indicated client #8 hit clients #1 and #3 while they were seated at the dining room table without causing significant injury. Corrective action included client #8's behavior plan would be revised and schedule revised to include defined tasks. Additional training was to be completed with staff regarding client #8.</p>		beyond the requirements of this level of home and were able to mitigate injury to consumers. All staff have been retrained on the AWS Abuse and Neglect Policy and were administered a post test to ensure their understanding of that training. All training has been reviewed by the director to ensure compliance.				

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	<p>-A report dated 9/19/11 indicated client #8 engaged in physical aggression to staff and property destruction, causing a wound to client #8 requiring first aid. Client #8 then eloped from the home while staff was completing documentation. A neighbor returned client #8 within 15 minutes and police arrived to ensure client #8 had returned to the home. Corrective action included increased supervision (within eyesight).</p> <p>-A report dated 10/8/11 at 3:00 PM indicated client #8 hit client #2 without apparent cause without causing injury. The report indicated client #8 may have been upset at not going on an outing earlier in the day. Corrective action included scheduling client #8's outings prior to other clients.</p> <p>-A report dated 10/8/11 at 7:15 PM indicated client #8 hit client #1 on top of her head while she was sitting at the table without causing injury. The report indicated client #8 may have been upset at not going on an outing earlier in the day. Corrective action included scheduling client #8's outings prior to other clients.</p> <p>-A report dated 10/9/11 indicated client #8 hit client #1 on the head without causing injury after being told he was not</p>			
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	<p>going on an outing. Corrective action included a referral to an alternative setting and a request for a medication of client #8's medicine by client #8's physician, and an evaluation of his behavior by a behavior analyst. A follow up report dated 10/14/11 indicated client #8 was taken to a mental health facility to be evaluated, he was physically aggressive to hospital staff, but was not admitted because the psychiatrist evaluated his physical aggression as "behavioral." Corrective action included providing extra staff support during "more challenging times," and indicated client #8 had been approved for alternate placement.</p> <p>-A report dated 10/5/11 indicated client #8 hit client #7 on top of his head as client #7 was sitting at the dining room table without causing injury. Corrective action indicated all supervision levels were in place. No additional corrective action was indicated.</p> <p>-A report dated 10/21/11 indicated client #8 hit client #7 on top of his head as client #7 was sitting at the dining room table without causing significant injury. No additional corrective action was indicated in the report.</p> <p>-A report dated 11/6/11 indicated client</p>						

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	<p>#8 exhibited property destruction and physical aggression on the way to his bedroom. Client #8 exited his bedroom, then hit staff in the face causing injury. Corrective action included additional staff training.</p> <p>-A report dated 11/12/11 indicated client #8 hit client #1 on top of her head while client #8 was being followed by staff without causing significant injury. Corrective action indicated client #8's transition meeting to an alternate setting and evaluation by the psychiatrist was scheduled for 11/14/11, and a second staff would be assigned to provide support and redirection for other clients when client #8 showed signs of agitation in addition to the extra staff already assigned to assist with client #8.</p> <p>The Residential Director and Qualified Developmental Disabilities Professional were interviewed on 1/17/12 at 4:31 PM and indicated client #8 had moved to an alternate setting in November, 2011 and despite interventions, client #8 had continued to exhibit physical aggression until he moved from the home.</p> <p>The facility's policy Group Home Abuse and Neglect dated 8/08 was reviewed on 1/19/12 at 2:00 PM and indicated the facility "...does not tolerate abuse in any</p>				

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	form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse....." 9-3-2(a)			
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W0157	<p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement immediate and effective corrective action to protect 3 of 4 sampled clients (clients #1, #2 and #3) and one additional client (client #7) from physical aggression after a pattern of physical aggression had been identified.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 1/17/12 at 4:10 PM and included the following reports involving discharged client #8:</p> <p>-A report dated 8/6/11 indicated client #8 hit client #7 on his head two times without injury. Corrective action indicated staff would position themselves between client #8 and other clients and staff were trained on ways to prevent aggression.</p> <p>-A report dated 8/8/11 indicated client #8 was admitted to a mental health facility and released on 9/1/11 to evaluate client #8 due to "behavioral incidents" with medication adjustments. The report indicated client #8 was being referred to</p>			W0157	<p>AWS placed client #8 on 7/19/11 at the urgent request from the state. Client #8 became physically aggressive beginning in August and AWS had him assessed by a behavior analyst and the plan was updated immediately and an emergency medication evaluation was scheduled on 8/8/11. At that time, AWS met with BDDS and an agreement was made to seek alternate placement for Client #8 due to his needs. Client #8 was admitted to a local psychiatric facility and remained there until 9/1/11 at which time he was believed to be stable. Additional staff training, staffing and BSP revisions were made regularly throughout this time as AWS waited on approval to move client #8 to an AWS ESN home. Although Client #8 was physically aggressive, AWS staff and their interventions were appropriate and did protect clients from injury. On one occasion, a consumer required basic first aid from staff but all other incidents went without injury. AWS did implement corrective action to protect clients as we waited on the state to approve client #8 for a more appropriate environment including interventions in the BSP, medication evaluation and inpatient medication adjustment, providing staffing above and beyond the requirements of this</p>		02/18/2012

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	<p>alternate placement.</p> <p>-A report dated 9/15/11 indicated client #1 was hit on the head by client #8 without causing injury. Corrective action included staff being placed between clients and client #8 and training would be provided to staff regarding client #8. No additional corrective action was available to review regarding the incidents or steps to prevent future occurrence.</p> <p>-A report dated 9/25/11 indicated client #8 hit client #1 on the head without causing injury. The report indicated client #8's plan had been implemented and staff redirected him to another area. Corrective action included a plan to change client #8's behavior plan and schedule.</p> <p>-A report dated 9/15/11 indicated client #8 hit clients #1 and #3 while they were seated at the dining room table without causing significant injury. Corrective action included client #8's behavior plan would be revised and schedule revised to include defined tasks. Additional training was to be completed with staff regarding client #8.</p> <p>-A report dated 9/19/11 indicated client #8 engaged in physical aggression to staff</p>		<p>level of home and were able to mitigate injury to consumers. All staff have been retrained on the AWS Abuse and Neglect Policy and were administered a post test to ensure their understanding of that training. All training has been reviewed by the director to ensure compliance.</p>				

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	<p>and property destruction, causing a wound to client #8 requiring first aid. Client #8 then eloped from the home while staff was completing documentation. A neighbor returned client #8 within 15 minutes and police arrived to ensure client #8 had returned to the home. Corrective action included increased supervision (within eyesight).</p> <p>-A report dated 10/8/11 at 3:00 PM indicated client #8 hit client #2 without apparent cause without causing injury. The report indicated client #8 may have been upset at not going on an outing earlier in the day. Corrective action included scheduling client #8's outings prior to other clients.</p> <p>-A report dated 10/8/11 at 7:15 PM indicated client #8 hit client #1 on top of her head while she was sitting at the table without causing injury. The report indicated client #8 may have been upset at not going on an outing earlier in the day. Corrective action included scheduling client #8's outings prior to other clients.</p> <p>-A report dated 10/9/11 indicated client #8 hit client #1 on the head without causing injury after being told he was not going on an outing. Corrective action included a referral to an alternative setting and a request for a medication of client</p>						

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	<p>#8's medicine by client #8's physician, and an evaluation of his behavior by a behavior analyst. A follow up report dated 10/14/11 indicated client #8 was taken to a mental health facility to be evaluated, he was physically aggressive to hospital staff, but was not admitted because the psychiatrist evaluated his physical aggression as "behavioral." Corrective action included providing extra staff support during "more challenging times," and indicated client #8 had been approved for alternate placement.</p> <p>-A report dated 10/5/11 indicated client #8 hit client #7 on top of his head as client #7 was sitting at the dining room table without causing injury. Corrective action indicated all supervision levels were in place. No additional corrective action was indicated.</p> <p>-A report dated 10/21/11 indicated client #8 hit client #7 on top of his head as client #7 was sitting at the dining room table without causing significant injury. No additional corrective action was indicated in the report.</p> <p>-A report dated 11/6/11 indicated client #8 exhibited property destruction and physical aggression on the way to his bedroom. Client #8 exited his bedroom,</p>						

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NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 6856 WHEELLOCK RD FORT WAYNE, IN 46835		
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	<p>then hit staff in the face causing injury. Corrective action included additional staff training.</p> <p>-A report dated 11/12/11 indicated client #8 hit client #1 on top of her head while client #8 was being followed by staff without causing significant injury. Corrective action indicated client #8's transition meeting to an alternate setting and evaluation by the psychiatrist was scheduled for 11/14/11, and a second staff would be assigned to provide support and redirection for other clients when client #8 showed signs of agitation in addition to the extra staff already assigned to assist with client #8.</p> <p>The Residential Director and Qualified Developmental Disabilities Professional were interviewed on 1/17/12 at 4:31 PM and indicated client #8 had moved to an alternate setting in November, 2011 and despite interventions, client #8 had continued to exhibit physical aggression until he moved from the home.</p> <p>9-3-2(a)</p>				

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W0312	<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.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #3), who received medication to address behavior related to medical procedures, the facility failed to develop and implement a plan to address the behavior.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 1/19/12 at 12:25 PM. Client #3's December, 2011 MAR (medication administration record) indicated he had been given Lorazepam 2 milligrams tab (antianxiety agent) prior to a medical procedure on 12/20/11. Client #3's dental exam dated 10/25/10 indicated "difficult today-only could polish-pt (patient) would not allow the hyg (hygienist) to scale. A dental exam dated 4/13/11 indicated client #3 "refused any form of treatment. Recommend sedation per IV (intravenously)." A dental exam dated 10/28/11 indicated client #3 "refused to get out of the van after arriving at the dentist office. IDT (interdisciplinary team) will meet." Client #3's behavior plan dated 5/17/11 and his Individual</p>	W0312	A desensitization plan has been developed to assist in decreasing the probability of medication usage and increase participation in dental and medical examinations for client #3. The director has completed a file review to ensure the desensitization plans are included for any consumer requiring restrictive interventions for appointments or those who are unable to successfully complete needed and required examinations. A check box has been added to the Human Rights Committee approval form that a desensitization plan is attached to any request for approval for medications to be administered as a pre-med to appointments.	02/18/2012	

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	<p>Support Plan dated 10/13/11 did not include a plan to address client #3's behavior related to medical appointments.</p> <p>The Qualified Developmental Disabilities Professional was interviewed on 1/19/12 at 12:50 PM and was unable to find a plan to address client #3's behavior during medical appointments.</p> <p>9-3-5(a)</p>			
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W0352	<p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #3), the facility failed to ensure he received an annual dental examination.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 1/19/12 at 12:25 PM. Client #3's dental exam dated 10/25/10 indicated "difficult today-only could polish-pt (patient) would not allow the hyg (hygienist) to scale. A dental exam dated 4/13/11 indicated client #3 "refused any form of treatment. Recommend sedation per IV (intravenously)." A dental exam dated 10/28/11 indicated client #3 "refused to get out of the van after arriving at the dentist office. IDT (interdisciplinary team) will meet." There was no additional evidence of a dental exam for client #3.</p> <p>The Qualified Developmental Disabilities Professional was interviewed on 1/19/12 at 2:00 PM and indicated there was no additional evidence of dental appointments for client #3.</p> <p>9-3-6(a)</p>	W0352	A desensitization plan has been developed to assist in decreasing the probability of mediation usage and increase participation in dental and medical examinations for client #3. The director has completed a file review to ensure the desensitization plans are included for any consumer requiring restrictive interventions for appointments or those who are unable to successfully complete needed and required examinations. A check box has been added to the Human Rights Committee approval form that a desensitization plan is attached to any request for approval for medications to be administered as a pre-med to appointments.	02/18/2012			

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