

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: May 15, 16 and 17, 2012.</p> <p>Facility Number: 003834 Provider Number: 15G708 AIMS Number: 200453440</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/23/12 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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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 1 sample client (client #2) with a behavior plan, the facility failed to specifically address client #2's intermittent slaps to her forehead.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 05/15/12 from 3:00 PM to 6:30 PM. Client #2 was observed to slap her forehead once at the following times: 3:20 PM, 4:20 PM, 4:22 PM, 4:35 PM, 5:18 PM and 5:44 PM. Staff #3 and #4 were present in the home and made no comment when client #2 slapped her forehead.</p> <p>Client #2's record was reviewed on 05/16/12 at 12:30 PM. Client #2's ISP (Individual Support Plan) dated 12/29/11 contained a BSP (Behavior Support Plan) dated 06/20/11. The BSP indicated client #2's behaviors included, but were not limited to, slaps to her face and head. The plan indicated, "Strategy when [client #2] is self-abusive: Respond to the first signs of agitation before [client #2] becomes self-injurious. Some of the intervention</p>	W0240	Ct #2's Behavior Support Plan was reviewed and modified by the IDT. The plan will be reviewed for approval by the Human Rights Committee. The changes to the plan indicate direction for staff on how to intervene during intermittent or periodic self-injurious behavior. All staff are being trained on the changes to the plan. The QMRP will complete the monthly report, which will be monitored by the director and the IDT to track success and effectiveness of the BSP revision. Quarterly meetings will be held to discuss client#2's progress, which will be attended and monitored by the Director.	06/16/2012	

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	<p>methods include: 1. Speak to her in a soft and reassuring voice. 2. Avoid too much touching. 3. Assess the environment...5. If she is hitting herself-intervene by placing a soft barrier between her hands and body to block...10. Once [client #2] had stopped being self injurious praise her and reassure her that you care about her...". The BSP did not indicate what to do if client #2 was periodically slapping herself.</p> <p>On 05/16/12 at 1:55 PM an interview with the Residential Director (RD) was conducted. The RD indicated the BSP did not describe what staff were to do when client #2 periodically slapped herself, it only described what to do if she slapped herself repeatedly.</p> <p>9-3-4(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 2 sampled clients (client #2), by not ensuring client #2's injury was immediately reported to the nurse and client #2's failure to ingest all of her medications was immediately reported to the nurse.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 05/15/12 from 3:00 PM to 6:30 PM. The observation included a medication administration with client #2 and staff #3 at 5:15 PM. Staff #3 obtained client #2's medications which included: Augmentin (antibiotic), Risperdal (mood disorder) and Calcium with Vitamin D (supplement). Staff #3 crushed the medications into small pieces and poured the medication onto the top of applesauce in a plastic medication cup. Client #2 moved her head back and forth during the attempt to spoon feed her the medication which resulted in client #2's forehead striking the counter. Some of the medications and applesauce not being ingested, landed on her arm, pants and the</p>	W0331	<p>All staff will receive re-training on reporting incidents of injury and review of medication administration procedures. This training will include when to contact the nurse and and the process for spilled or uningested medications. Post-tests will be completed to ensure their understanding of the training. Medication administration guidelines are being developed for Ct#2 which will address techniques to prevent injury and promote ingestion of medications. All staff will receive training on the medication administration guidelines. The QMRP, Residential Manager, or Nurse will observe medication administration for all staff for three months to ensure that the guidelines and the training are effective. Monthly medication administration spot checks will be completed thereafter. The observations will be documented on a medication observation sheet and turned into the Residential Director for review.</p>	06/16/2012	

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	<p>floor. Three separate pieces of the medications were on the floor. At 5:16 PM an interview with staff #3 was conducted and she indicated client #2 did not get all of the medications and pill pieces were on the floor. Client #2's forehead was red where she had struck it and the skin was intact. At the time client #2's head struck the counter, staff #3 stated, "oh my." The observation in the group home ended at 6:30 PM. Staff #3 had not shared the information by calling the nurse or filling out an incident/accident report regarding client #2's forehead striking the counter, or the fact that client #2 did not receive all of her medications.</p> <p>An interview was conducted on 05/16/12 at 8:00 AM with the Qualified Mental Retardation Profession (QMRP). The QMRP indicated she had not received an incident/accident form regarding any incident of client #2 striking her forehead on the counter.</p> <p>An interview was conducted on 05/16/12 at 1:55 PM with the Residential Director (RD). She indicated staff #2 should have contacted the group home nurse regarding client #2 striking her forehead on the counter and also contacted the group home nurse immediately after the medication administration of client #2 to</p>			

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	<p>discuss the situation. The RD indicated she had spoken with the group home nurse who was aware client #2 had hit her head, but not aware that client #2 did not get all her medication.</p> <p>9-3-6(a)</p>				