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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G721 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/07/2014 |
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| W000000            | <p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: February 26, 27, 28, March 3 and 7, 2014.</p> <p>Facility Number: 004492<br/>Provider Number: 15G721<br/>AIM Number: 200512660</p> <p>Surveyor: Jo Anna Scott, QIDP.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 20, 2014 by Dotty Walton, QIDP.</p>   | W000000       |  |                      |
| W000249            | <p>483.440(d)(1)<br/>PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 4 clients living in the home (clients #2 and #4), the facility failed to ensure program implementation and activities were provided at all times of opportunity.</p> <p>Findings include:</p> | W000249       | <p>AWS QDDP and Residential Managers will re-train all staff in the home regarding the appropriate method for implementing active treatment. This updated training will focus on involving clients in daily routine activities, as well as implementing ISP goals. AWS QDDP and Residential Managers will monitor staff 3 times weekly for 3</p> | 04/06/2014           |

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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|  | <p>During the observation period on 2/27/14 from 10:30 AM to 3:30 PM, client #2 and client #4 did not attend the day program because of health issues. Client #2 spent the day in a recliner watching television. Staff did assist him from the recliner at 12:00 PM to his wheelchair to come to the kitchen table for lunch. Client #2's meal was prepared and served by staff #5. After eating his lunch he went to the restroom with staff assistance and returned to the recliner. Client #2 remained in the chair watching television the rest of the time. Client #4 was in her recliner from 10:30 AM to 12:00 PM. Client #4 transferred to her wheelchair at 12:00 PM with staff assistance. Client #4 ate her lunch with staff assistance and stayed in the wheelchair the rest of the afternoon. Client #4 tried to open the door to the outside or to the garage from 12:45 PM to 3:30 PM. When client #4 was able to get the door open, staff #5 would move client #4 via her wheelchair back into the living room. Client #4 immediately turned the wheelchair around and would go back to try and open the door. Client #4 was not presented with any other activity.</p> <p>The record review for client #2 was conducted on 2/27/14 at 10:30 AM. The ISP (Individual Support Plan) dated 7/10/13 indicated client #2 had the following training objectives:<br/>"1. [Client #2] will assist with meal activities by serving himself appropriate amounts of food at meals and by packing his lunch for Day Services.<br/>2. [Client #2] will shave himself with an electric razor.<br/>3. [Client #2] will assist with medication administration by throwing away his medication cup.</p> |   | consecutive months to ensure that active treatment is implemented for all clients in the home. After the 3 months, monitoring will continue one time per week. AWS QDDP and Residential Managers will monitor staff at other group homes 3 times weekly for three consecutive months to ensure that active treatment is implemented for all clients who may also be effected by this deficient practice. |  |  |   |  |

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|  | <p>4. [Client #2] will participate in a minimum of 2 community based activities monthly engaging in sociably acceptable behavior.</p> <p>5. [Client #2] will learn to thoroughly rinse all soap from his hair and body.</p> <p>6. [Client #2] will hand the cashier the correct amount of cash to pay for his purchase.</p> <p>7. [Client #2] will assist with his laundry by putting his clothes into his chest of drawers.</p> <p>8. [Client #2] will participate in light exercise once a day."</p> <p>The record review for client #4 was conducted on 2/27/14 at 1:19 PM. The ISP dated 2/27/13 indicated client #4 had the following training objectives:</p> <p>"1. [Client #4] will assist with bathing by washing her hair with hand over hand assistance.</p> <p>2. [Client #4] will cooperate with being dressed.</p> <p>3. [Client #4] will eat at a slower rate.</p> <p>4. [Client #4] will cooperate with the brushing of her teeth.</p> <p>5. [Client #4] will assist with various laundry tasks given hand over hand assistance.</p> <p>6. [Client #4] will assist with medication administration by taking a drink after receiving her medications.</p> <p>7. [Client #4] will learn to remain calm while shopping.</p> <p>8. [Client #4] will participate in 2 group activities per day.</p> <p>9. [Client #4] will participate in 2 community based activities.</p> <p>10. [Client #4] will cooperate with the brushing of her teeth.</p> <p>11. [Client #4] will assist with various meal activities.</p> <p>Interview with administrative staff #2 on 3/3/14 at 2:30 PM indicated clients #2 and #4</p> |   |   |                      |   |

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| W000322            | <p>should have participated in the preparation of their noon meal and should have been presented with other activities/training during the day.</p> <p>9-3-4(a)<br/>483.460(a)(3)<br/>PHYSICIAN SERVICES<br/>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review, observation and interview for 1 of 4 clients living in the home (client #4), the facility failed to ensure the OT (Occupational Therapist) recommendation was followed.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 2/27/14 at 12:46 PM. The record indicated client #1 was evaluated on 1/14/14 by an Occupational Therapist. The OT recommended a "Carrot" shaped soft splint to provide palm protection in both hands.</p> <p>During the observation period on 2/27/14 from 6:00 AM to 9:00 AM and 10:30 AM to 3:30 PM, client #2 did not have anything in her hands.</p> <p>Interview with administrative staff #2 on 2/27/14 at 1:00 PM indicated they used a wash cloth in the client's hands and had not provided the "Carrot" shaped soft splint.</p> | W000322       | The AWS Nurse will ensure that all needed OT equipment is available for each client. The AWS Nurse will review all OT recommendations for each client and determine if all recommendations are currently in place, and being implemented and documented appropriately. The AWS Nurse will monitor each OT recommendation and ensure implementation. The AWS Nurse will report at each client's quarterly IDT meeting the progress and data related to each OT recommendation. A monthly quality assurance checklist will be completed for each client at each group home verifying that all physician and therapist recommendations are being implemented. This checklist will be reviewed monthly by the AWS Director to ensure that all recommendations from each discipline are followed. | 04/06/2014           |
| W000368            | <p>9-3-6(a)<br/>483.460(k)(1)<br/>DRUG ADMINISTRATION<br/>The system for drug administration must</p>   |               |  |                      |

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|  | <p>assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on observation, record review and interview for 2 of 4 clients living in the home (clients #1 and #2), the facility failed to ensure the medication was administered according to the physician's orders.</p> <p>Findings include:</p> <p>1. During the observation period on 2/27/14 from 6:15 AM to 8:45 AM, the morning medication administration was started at 7:45 AM. Client #1 received Polyethylene Glycol Powder unmeasured and sprinkled into a cup of water from the container for constipation, Senna Laxative 8.6 mg (milligram) for constipation, Metoprolol Succinate 50 mg for hypertension and Glycopyrrolate 1 mg for stomach. The Polyethylene Glycol Powder was poured without measuring into a 4 ounce cup of water. The powder was not stirred into the water. Client #1 did not have his blood pressure taken during this time.</p> <p>The physician's orders for client #1 dated January 1 through January 31, 2014 were reviewed on 2/27/14 at 8:40 AM. The administrative staff #3, on 2/27/14 at 8:30 AM, indicated the nurse had the February physician's orders and there hadn't been any changes. The medication administration records were dated 2/1/14 through 2/28/14. The physician's orders indicated the following instructions for the Polyethylene Glycol Powder:<br/>"Give 17 Grams (1 capful) in 8 oz (ounces) water or juice and drink daily for constipation."<br/>The Metoprolol had instructions as follows: "</p> | W000368   | The AWS Nurse will review and document appropriate medication administration steps and diet orders during a medication pass with the AWS employee identified as the staff responsible for passing medications in tag W368. The AWS Nurse will complete a skills check off review with the employee identified as passing medication in tag W368 to insure appropriate compliance with med pass procedures and the following of diet orders during med pass. The AWS Nurse will complete random weekly med skills check off observations for the next 3 months with various AWS group home staff to ensure appropriate medication administration compliance and correct implementation of diet orders during med passes. | 04/06/2014   |  |   |  |

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| W000460  | <p>B/P (Blood Pressure) before med. (medication)."</p> <p>2. The medication administration for client #2 was conducted at 8:20 AM. Client #2 received Aspirin 81 mg - anticoagulant, Atorvastatin 10 mg - cholesterol, Calcium 500 mg - supplement, Dilantin 100 mg - seizures, Famotidine 20 mg - ulcer, Hydrochlorothiazide 25 mg - edema, Fluoxetine 40 mg - anxiety, Naproxen 500 mg - arthritis, Levetiracetam 500 mg and 1000 mg - seizures, Thera -M - diet supplement, Tegretol 400 mg - seizures.</p> <p>Review of the physician's orders dated January 1 through January 31, 2014 for client #2 was conducted on 2/27/14 at 10:30 AM. The physician's orders for the calcium had the following instructions: "Give 4 hours from other meds (medications)."</p> <p>A phone interview with staff #6, RN (Registered Nurse) on 3/3/14 at 2:30 PM indicated the Polyethylene Glycol Powder should have been blended into the water and a capful should have been measured before adding it to the water. Staff #6, RN, indicated the Metoprolol should not have been given without the blood pressure taken. Staff #6, RN, indicated client #2 was not supposed to get the Calcium with iron and the instructions were incorrect from the pharmacy.</p> <p>9-3-6(a)<br/>483.480(a)(1)<br/>FOOD AND NUTRITION SERVICES<br/>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> | W000460   | The AWS Nurse will review and document appropriate medication   | 04/06/2014   |  |   |  |

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|  | <p>Based on observation, record review and interview for 1 of 4 clients living in the home (client #3), the facility failed to ensure the staff followed the diet order during the morning medication pass.</p> <p>Findings include:</p> <p>During the observation period on 2/27/14 from 6:15 AM to 8:45 AM client #3 received his medication at 7:55 AM. Client #3 received Risperidone 1 mg (milligram) for psychosis, Macrochantin 25 mg for UTIs (Urinary Tract Infections), and Loratadine 10 mg for allergies. Staff #6 popped the medication from the bubble pack, gave the medication in applesauce, poured a 4 oz (ounce) cup of water (unthickened) and gave client #3 a drink.</p> <p>The record review for client #3 was conducted on 2/27/14 at 1:19 PM. The Individualized Support Plan dated 7/22/13 indicated client #1 had a regular diet with pureed food and honey thick liquids.</p> <p>Interview with administrative staff #3 on 2/27/14 at 2:00 PM indicated the medication should have been given with applesauce and the water should have been honey thick.</p> <p>9-3-8(a)</p> |   | <p>administration steps and diet orders during a medication pass with the AWS employee identified as the staff responsible for passing medications in tag W368. The AWS Nurse will complete a skills check off review with the employee identified as passing medication in tag W368 to insure appropriate compliance with med pass procedures and the following of diet orders during med pass. The AWS Nurse will complete random weekly med skills check off observations with various AWS group home staff for the next three months to ensure appropriate medication administration compliance and correct implementation of diet orders during med passes.</p> |  |  |   |  |