STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G710	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	55883 RING NECK DR OSCEOLA, IN 46561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: August 6, 7, 8, and 9, 2013 Facility number: 003864 Provider number: 15G710 AIM number: 200460480 Surveyor: Tim Shebel, LSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/19/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G710	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	55883 RING NECK DR OSCEOLA, IN 46561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise operating direction over the facility to keep light fixtures clean and in working order for 2 of 2 sampled clients (clients #1 and #2), and 2 additional clients (clients #3 and #4). Findings include: The group home where clients #1, #2, #3, and #4 resided was observed during the 8/8/13 observation period from 2:31 P.M. until 5:30 P.M. The ceiling light fixture in the kitchen was noted to have a cracked and broken cover with dead insects in the plastic cover. Two of the four fluorescent bulbs in the ceiling light fixtures in the medication room/laundry area did not work. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 8/9/13 at 8:03 A.M. QIDP #1 indicated the facility's maintenance department was in charge of cleaning the lighting fixtures and they should be cleaned and repaired. 9-3-1(a)	W000104	The light bulbs in the light fixture have been changed and the cover has been cleaned. The managers complete a home maintenance walk through monthly, but should be attending to immediate needs on a more regular basis. The management staff will be completing weekly walkthroughs of the home in addition to their monthly reviews and will report any issues to the maintenance company immediately. The walk through reports will be monitored by the director to ensure compliance and the director will ensure that the maintenance issues are addressed within a timely manner by the maintenance company or assigned to another contractor as needed.	09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G710	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	55883 RING NECK DR OSCEOLA, IN 46561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G710	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	55883 RING NECK DR OSCEOLA, IN 46561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure direct care staff wiped excessive saliva from the mouth and chin area of 1 of 2 additional clients (client #4). Findings include: Client #4 was observed at the group home during the 8/8/13 observation period from 2:31 P.M. until 5:30 P.M.. During the observation period, client #4 excessively drooled from his mouth. The drool continuously dropped onto the client's shirt which was completely wet from the drool. During the observation period, Direct care staff #3, #5, #6, and QIDP (Qualified Intellectual Disabilities Professional) #1 did not assist or prompt client #4 to wipe his mouth and chin area. QIDP #1 was interviewed on 8/9/13 at 8:03 A.M.. QIDP #1 indicated client #4 drools continuously and direct care should have prompted or assisted client #4 in wiping his mouth and chin area. 9-3-5(a)	W000268	Client #4's mouth should be wiped on a routine basis due to his drooling. All staff have received re-training on this requirement. If client #4's shirt becomes wet, staff have been instructed to assist in changing client #4 immediately. The professional staff have also been trained by the director on this care required by client #4. Observation sheets will be completed to ensure that all the training has been effective and that client #4 is receiving assistance as needed. The monitoring sheets will be reviewed by the director to ensure compliance.	09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G710	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	55883 RING NECK DR OSCEOLA, IN 46561

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE