STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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 investigation of complaint #IN00132685. Complaint #IN00132685: Substantiated. Federal and state deficiencies related to the allegation are cited at W149, W156, W331 and W368. Dates of Survey: August 7, 8 and 9, 2013. Facility Number: 003863 Provider Number: 15G713 AIMS Number: 200462800 Surveyor: Claudia Ramirez, RN These 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: 15G713	(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	55021 BIRCH RD 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
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports, the facility failed to implement the facility's policy and procedure to ensure an investigation was completed within 5 days for client A. Findings include: On 08/07/13 at 11:26 AM a record review of the BDDS reports was completed and included the following: 06/21/13: A BDDS report indicated, "[Client A] is a [age] year old male who lives in a group home for adults with extensive medical needs operated by AWS. His diagnoses include Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. [Client A] was evaluated in the ER (Emergency Room) on the morning of 6/21/13. Blood work, ultrasound of abdomen and chest x-ray were completed. Lab results indicated low potassium with kidney dysfunction. Abdominal ultrasound showed significant	W000149		09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	amounts of gas and fecal impaction was ruled out. Chest x-ray was negative for infection. [Client A] is being admitted for stabilization of potassium and further evaluation." 06/28/13: A BDDS follow-up report for the 06/21/13 incident indicated, "[Client A] was evaluated in the ER on 06/21/13 due to abdominal distention. He was admitted to the hospital due to low potassium and for further evaluation of abdominal distention. A colonoscopy was completed which indicated that his colon tipped back as a result of megacolon and inhibited his bowels from evacuating. Feces was removed from the colon during the procedure and the colon began to resolve itself back to a functioning position. He also received IV (intravenous) potassium and his heart function was assessed to be within normal limits. [Client A] was discharged on 06/28/13 after it was determined that bowel function had been resolved. His anticonvulsant medications were adjusted by his neurologist while he was in the hospital. His potassium level returned to normal and no supplementation is required. He does not require any changes to his bowel regimen. [Client A] will be monitored for any changes in condition and he will be referred to his primary physician as indicated."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	07/13/13: A BDDS report indicated, "[Client A] is a [age] year old male who lives in a group home for adults with extensive medical needs operated by AWS. His diagnoses include Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. "[Client A] was recently hospitalized for 7 days due to abdominal distention which was a result of his colon tipping backwards and inhibiting his bowels from moving....His bowel status was determined to be at his baseline on discharge from the hospital and no modifications to his bowel regimen were required. Upon awakening on the morning of 7/13/13, [client A] was noted to have abdominal distention and his prn (as needed) bowel regimen was initiated per instructions of the nurse. Initiation of bowel regimen medications did not result in bowel elimination or decreased distention. After assessment by the nurse, he was sent to [hospital] - ER for evaluation. [Client A] was admitted to the hospital for evaluation and treatment of abdominal distention. A GI (gastrointestinal) consult was obtained and possible surgery was planned for 7/14/13 to relieve trapped air from the colon which had again tipped backwards			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	and inhibited elimination...." 07/14/13: A BDDS report indicated, "... [Client A] was admitted to the hospital for evaluation and treatment of abdominal distention. A GI (gastrointestinal) consult was obtained and possible surgery was planned for 7/14/13 to relieve trapped air from the colon which had again tipped backwards and inhibited elimination. However, around 5:00 am on 7/14/13, [client A] had a sudden cardiac arrest and CPR (Cardiopulmonary resuscitation) was initiated which was ineffective in reviving him. [Client A] was pronounced dead around 5:30 am." On 08/08/13 at 10:00 AM a review of the undated, "Conclusion of the Internal Mortality Investigation" was conducted. The document indicated client A's date of death was 07/14/13. The document indicated, "...Conclusion of the investigation: Review of nurses notes, MARs (Medication Administration Records), BM (bowel movement) pattern documentation and staff interviews, revealed that [client A] did not experience any significant changes in health status prior to awakening on the morning of 7/13/13. He had been recently hospitalized from 6/21/13 to 6/28/13 for abdominal distention which was a result of megacolon that had tipped onto itself which inhibited elimination of gas and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	feces. This was resolved with decompression of the colon and surgical intervention was not warranted at that time...[Client A's] appetite returned to his baseline and his activity level was increasing in the week after his hospitalization. His bowel movement pattern showed elimination of large stool daily to every other day up until the morning of 7/13/13. His abdomen had remained soft and round with active bowel sounds in all 4 quadrants...He slept well that night and upon awakening in the morning his abdomen was noted to be distended. The nurse was contacted and assessment was completed which resulted in [client A] being evaluated in the ER. The verbal report from the ER indicated that [client A] was exhibiting a recurrence of the previous issue of the colon tipping backwards on itself and causing trapped air. He was admitted with plans for possible surgery the following day...Around 5 am, [client A] suffered cardiac arrest and code blue was called by the hospital staff which was ineffective in reviving him. Awaiting discharge summary from the hospital." The investigation did not indicate the date it was completed or who conducted the investigation. On 08/07/13 at 2:11 PM, a review of the facility's 08/2008 Policy on Group Home			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	Abuse and Neglect indicated, "...Results of the investigation must be reported within 5 days...." On 08/08/13 at 1:00 PM an interview was conducted with the Area Director (AD). The AD indicated the Policy and Procedure on Abuse/Neglect indicated the investigation was to be completed in 5 days. She indicated the policy was not followed as the investigation was not completed and they were waiting on the discharge summary from the hospital. She indicated the document did not contain a date or any information as to when or who conducted the investigation. This federal tag relates to complaint #IN00132685. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to assure the investigation for 1 of 1 client death (client A) was investigated and completed within 5 working days. Findings include: On 08/07/13 at 11:26 AM a record review of the BDDS reports was completed and included the following: 06/21/13: A BDDS report indicated, "[Client A] is a [age] year old male who lives in a group home for adults with extensive medical needs operated by AWS. His diagnoses include Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. Client A] was evaluated in the ER (Emergency Room) on the morning of 6/21/13. Blood work, ultrasound of abdomen and chest x-ray were completed. Lab results indicated low potassium with kidney dysfunction.	W000156	Since this investigation involved a death of a consumer who suffered a heart attack while in the hospital, the Indiana Bureau of Quality Improvement Services allows for a 30 day review as indicated by the Mortality Review Process. AWS did not investigate this as a case of Abuse and Neglect. Given that this was a mortality review the investigation was not required by any entity other than AWS by the 5 th day, a verbal report was sufficient per policy for the preliminary review until all information could be obtained from the hospital where the consumer passed away. Therefor AWS is disputing this citation as the Regional Director was being notified of the incidents and information as it was being obtained and until the final investigation was completed per the BQIS Mortality Review Process. The AWS Abuse and Neglect Policy will be updated to include instructions for the investigator when the investigation cannot be concluded within 5 days. This will include the the report be signed on the 5th day and marked as the "Preliminary" conclusion. The Regional Director (designee) will	09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	Abdominal ultrasound showed significant amounts of gas and fecal impaction was ruled out. Chest x-ray was negative for infection. [Client A] is being admitted for stabilization of potassium and further evaluation." 06/28/13: A BDDS follow-up report for the 06/21/13 incident indicated, "[Client A] was evaluated in the ER on 06/21/13 due to abdominal distention. He was admitted to the hospital due to low potassium and for further evaluation of abdominal distention. A colonoscopy was completed which indicated that his colon tipped back as a result of megacolon and inhibited his bowels from evacuating. Feces was removed from the colon during the procedure and the colon began to resolve itself back to a functioning position. He also received IV (intravenous) potassium and his heart function was assessed to be within normal limits. [Client A] was discharged on 06/28/13 after it was determined that bowel function had been resolved. His anticonvulsant medications were adjusted by his neurologist while he was in the hospital. His potassium level returned to normal and no supplementation is required. He does not require any changes to his bowel regimen. [Client A] will be monitored for any changes in condition and he will be referred to his		also sign by the 5th day that a preliminary review has been completed. The Regional Director will provide training and will monitor for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	primary physician as indicated." 07/13/13: A BDDS report indicated, "[Client A] is a [age] year old male who lives in a group home for adults with extensive medical needs operated by AWS. His diagnoses include Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. "[Client A] was recently hospitalized for 7 days due to abdominal distention which was a result of his colon tipping backwards and inhibiting his bowels from moving....His bowel status was determined to be at his baseline on discharge from the hospital and no modifications to his bowel regimen were required. Upon awakening on the morning of 7/13/13, [client A] was noted to have abdominal distention and his prn (as needed) bowel regimen was initiated per instructions of the nurse. Initiation of bowel regimen medications did not result in bowel elimination or decreased distention. After assessment by the nurse, he was sent to [hospital] - ER for evaluation. [Client A] was admitted to the hospital for evaluation and treatment of abdominal distention. A GI (gastrointestinal) consult was obtained and possible surgery was planned for 7/14/13 to relieve trapped air from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	colon which had again tipped backwards and inhibited elimination...." 07/14/13: A BDDS report indicated, "... [Client A] was admitted to the hospital for evaluation and treatment of abdominal distention. A GI (gastrointestinal) consult was obtained and possible surgery was planned for 7/14/13 to relieve trapped air from the colon which had again tipped backwards and inhibited elimination. However, around 5:00 am on 7/14/13, [client A] had a sudden cardiac arrest and CPR (Cardiopulmonary resuscitation) was initiated which was ineffective in reviving him. [Client A] was pronounced dead around 5:30 am." On 08/08/13 at 10:00 AM a review of the undated, "Conclusion of the Internal Mortality Investigation" was conducted. The document indicated client A's date of death was 07/14/13. The document indicated, "...Conclusion of the investigation: Review of nurses notes, MARs (Medication Administration Records), BM (bowel movement) pattern documentation and staff interviews, revealed that [client A] did not experience any significant changes in health status prior to awakening on the morning of 7/13/13. He had been recently hospitalized from 6/21/13 to 6/28/13 for abdominal distention which was a result of megacolon that had tipped onto itself			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	which inhibited elimination of gas and feces. This was resolved with decompression of the colon and surgical intervention was not warranted at that time...[Client A's] appetite returned to his baseline and his activity level was increasing in the week after his hospitalization. His bowel movement pattern showed elimination of large stool daily to every other day up until the morning of 7/13/13. His abdomen had remained soft and round with active bowel sounds in all 4 quadrants...He slept well that night and upon awakening in the morning his abdomen was noted to be distended. The nurse was contacted and assessment was completed which resulted in [client A] being evaluated in the ER. The verbal report from the ER indicated that [client A] was exhibiting a recurrence of the previous issue of the colon tipping backwards on itself and causing trapped air. He was admitted with plans for possible surgery the following day...Around 5 am, [client A] suffered cardiac arrest and code blue was called by the hospital staff which was ineffective in reviving him. Awaiting discharge summary from the hospital." The investigation did not indicate the date it was completed or who conducted the investigation. On 08/08/13 at 1:00 PM an interview was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	conducted with the Area Director (AD). She indicated the investigation was not completed in 5 days as they were waiting on the discharge summary from the hospital. She indicated the document did not contain a date or any information as to when or who conducted the investigation. This federal tag relates to complaint #IN00132685. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility nursing services failed for 1 of 3 sampled clients (client A), to ensure medication orders were accurate on the MAR (Medication Administration Record), medications were given as ordered and new medications were started when prescribed. Findings include: Client A's records were reviewed on 08/07/13 at 2:35 PM. The record contained the following dated documents: 05/20/13: Annual Physical examination indicated client A's diagnoses included but were not limited to: Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. 06/28/13: Hospital Discharge Summary indicated client A had been hospitalized from 06/21/13 until 06/28/13. The Discharge Summary indicated, "Discharge Diagnoses: 1. Abdominal distention and megacolon due to	W000331	The Residential Director will retrain the nurses and managers on the transcription of new orders per the AWS Medication Administration Policy. The second nurse or manager will complete a buddy check after the order is transcribed to ensure accuracy. Any new prescriptions, upon hospital discharge will be obtained from the local pharmacy to ensure timliness and availability. All new orders upon hospital discharge will be sent to the Residential Director so compliance can be monitored.	09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	pseudoobstruction; resolved. 2. Electrolyte imbalance (hypokalemia (low potassium), hypophysphatemia (low phosphorus); due to diarrhea; corrected. 3. Seizure disorder; improved but was still with continued seizure activity, though less from initial during this admission. The patient has been cleared for discharge by Neurology, [name]. 4. History of cerebral palsy with mood disorder, mental retardation and aphasis (language disorder)...The patient has been seen by [Dr name] yesterday, who made further adjustments of the patient's antiepileptic medication and resumed oral Dilantin and Depakote (for seizures) and therefore recommended that the patient be discharged and follow up with him in his office next week...." 06/28/13: A "Comprehensive Physician's Order Sheet For: Telephone/Standing/Clarified Orders" dated 06/28/13 written by the group home RN (Registered Nurse) for client A indicated, "Clarification order: Resume previous diet and medications: D/C (discontinue) Lamotrigine (Lamictal) (seizures) 25 mg (milligram) D/C Calcium Carbonate (calcium supplement) Add the following medication: Lamictal 200 mg tab (tablet) (seizures) - 1 tab PO (orally) BID (twice daily)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	Lamotrigine (Lamictal) 100 mg tab - 1 tab PO Q (every) HS (hour of sleep) (For a total of Lamictal 200 mg in the AM and 300 mg in the PM) Dilantin (Phenytoin) (seizures) 200 mg tab PO Q 12 HRS (hours) Depakote (Divalproex Sodium) (seizures) 500 mg - 1 tab PO TID (3 times a day) Oyster Shell Calcium with Vit (vitamin) D 500 mg/200 units - 1 tab PO daily Magnesium Oxide (supplement) - 800 mg daily." 06/2013: June 2013 MAR (Medication Administration Record) indicated client A received the following regarding the 8 PM Lamictal dose: 06/29, 30/13: Lamictal 100 mg at 8 PM 06/29, 30/13: Lamictal 200 mg at 8 PM 06/29, 30/13: Lamictal 100 mg at 8 PM For a total dose of Lamictal 400 mg at 8 PM on 06/29/13 and 06/30/13. The June 2013 contained the Lamictal 100 mg order on it twice. The hospital discharge order of 06/28/13 and the clarification of the order dated 06/28/13 indicated the total dose of the Lamictal was to be 300 mg. Client A received a total dose of Lamictal 400 mg on 06/29/13 and 06/30/13 and not the 300 mg as ordered. 06/2013: June 2013 MAR indicated client A was to start on Depakote 500 mg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	- 1 tab PO TID on 06/28/13. The medication doses were scheduled for 8 AM, 2 PM and 8 PM. The MAR indicated client A did not receive the medication on 06/28/13 at 8 PM or on 06/29/13 at 8 AM for a total of 1000 mg in missed dosage. The MAR indicated the medication was "not sent" from pharmacy yet. 06/2013: June 2013 MAR indicated client A was to start on Dilantin (Phenytoin) (seizures) 200 mg tab PO Q 12 HRS (hours) on 06/28/13. The medication doses were were scheduled for 8 AM and 8 PM. The MAR indicated client A did not receive the medication on 06/28/13 at 8 PM or on 06/29/13 at 8 AM for a total of 400 mg in missed dosage. The MAR indicated the medication was "not sent" from pharmacy yet. 06/2013: June 2013 MAR indicated client A was to start on 06/28/13 at 8 PM two new medications which included: Oyster Shell Calcium with Vit (vitamin) D 500 mg/200 units - 1 tab PO daily Magnesium Oxide (supplement) - 800 mg daily. The MAR indicated client A did not receive the medications on 06/28/13 at 8 PM. The MAR indicated the medications were "not sent" from pharmacy yet.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	06/2013: June 2013 MAR indicated client A was to start on Dilantin (Phenytoin) (seizures) 200 mg tab PO Q 12 HRS (hours) on 06/28/13 at 8 PM. The MAR indicated client A did not receive the medications on 06/28/13 at 8 PM or the 06/29/13 8 AM scheduled dose. The MAR indicated the medication was "not sent" from pharmacy yet. 06/29/13: Nursing notes indicated, "Followed up with pharmacy regarding delivery of Depakote and Dilantin. Dr [name] notified, no seizure activity." 07/02/13: Doctor Visit Form indicated client A was seen by his physician for follow-up of his seizures as per the hospital discharge instructions. The form indicated the Dr ordered the following medication change: "Reduce Dilantin to 100 mg - 1 am/2 pm for 3 days (300 mg daily); the 1 am/1 pm for three days; then 1 q hs (100 mg daily) times three days; then off." The order indicated client A was to have 100 mg of Dilantin in the AM and 200 mg of Dilantin in the PM for 3 days; then 100 mg in the AM and 100 mg in the PM for 3 days; then 100 mg at HS for 3 days then off. 07/02/13: Nurses notes by the LPN (Licensed Practical Nurse) indicated, "Client went to Dr [name] office for f/u			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	(follow-up). Received new orders to taper off of Phenytoin (Dilantin). Group home staff informed. Will see Dr [name] again in 2 weeks." 07/2013: July 2013 MAR contained the hand written orders from the 07/02/13 Dr visit. The July 2013 MAR indicated the Dilantin reduction was started on 07/02/13. Client A received the following Dilantin doses: 07/02/13 - Dilantin 200 mg in the AM and 200 mg in the PM for a total dose of 400 mg. 07/03/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 300 mg. 07/04/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 300 mg. 07/05/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/06/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/07/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/08/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/09/13 - Dilantin 100 mg in the PM for a total dose of 100 mg.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	07/10/13 - Dilantin 100 mg in the PM for a total dose of 100 mg. The July 2013 MAR did not follow the Dr orders for the Dilantin reduction. 07/03/13: Nurses notes by the LPN indicated, "Received call from [name], Dr [name] office that Vitamin D level is still low. Wants to change from the capsule to the liquid preparation for better absorption. To have Vit D level rechecked in 2 months. Order for Vit D preparation changed to liquid sent to [name] pharmacy electronically from Dr [name] office." 07/03/13: A "Comprehensive Physician's Order Sheet For: Telephone/Standing/Clarified Orders" dated 07/03/13 written by the LPN indicated, "Recheck Vit D level in 2 months. D/C Vitamin D capsule 500,000 U (unit) tablet. Give Engocalcifenol 4 ml (milliliter) once every week - Vitamin supplement." 07/2013: July 2013 MAR indicated client A received the first Vit D dose of the 07/03/13 order on 07/08/13. On 08/08/13 at 1:00 PM an interview was conducted with the Area Director (AD). The AD indicated client A's medications were changed when he was discharged from the hospital on 06/28/13, again on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	07/02/13 and on 07/03/13. The AD indicated the MAR should correctly reflect those changes. She indicated the nurse should ensure the medications were in the home so the medications could be given as per the physician orders. She indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. This federal tag relates to complaint #IN00132685. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A), who take medications prescribed by the physician, to administer medications as ordered. Findings include: Client A's records were reviewed on 08/07/13 at 2:35 PM. The record contained the following dated documents: 05/20/13: Annual Physical examination indicated client A's diagnoses included but were not limited to: Moderate MR (Mental Retardation), Cerebral palsy, Seizure Disorder, Vagus Nerve Stimulator, Impulse Control Mood Disorder, Constipation, and Hyperammonemia. 06/28/13: Hospital Discharge Summary indicated client A had been hospitalized from 06/21/13 until 06/28/13. The Discharge Summary indicated, "Discharge Diagnoses: 1. Abdominal distention and megacolon due to pseudoobstruction; resolved. 2. Electrolyte imbalance (hypokalemia,	W000368	The Residential Director will retrain the nurses and managers on the transcription of new orders per the AWS Medication Administration Policy. The second nurse or manager will complete a buddy check after the order is transcribed to ensure accuracy. Any new prescriptions, upon hospital discharge will be obtained from the local pharmacy to ensure timliness and availability. All new orders upon hospital discharge will be sent to the Residential Director so compliance can be monitored.	09/09/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	hypophysphatemia; due to diarrhea; corrected. 3. Seizure disorder; improved but was still with continued seizure activity, though less from initial during this admission. The patient has been cleared for discharge by Neurology, [name]. 4. History of cerebral palsy with mood disorder, mental retardation and aphasis...The patient has been seen by [Dr name] yesterday, who made further adjustments of the patient's antiepileptic medication and resumed oral Dilantin and Depakote (for seizures) and therefore recommended that the patient be discharged and follow up with him in his office next week...." 06/28/13: A "Comprehensive Physician's Order Sheet For: Telephone/Standing/Clarified Orders" dated 06/28/13 written by the group home RN (Registered Nurse) for client A indicated, "Clarification order: Resume previous diet and medications: D/C (discontinue) Lamotrigine (Lamictal) (seizures) 25 mg (milligram) D/C Calcium Carbonate (calcium supplement) Add the following medication: Lamictal 200 mg tab (tablet) (seizures) - 1 tab PO (orally) BID (twice daily) Lamotrigine (Lamictal) 100 mg tab - 1 tab PO Q (every) HS (hour of sleep) (For a total of Lamictal 200 mg in the AM			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	and 300 mg in the PM) Dilantin (Phenytoin) (seizures) 200 mg tab PO Q 12 HRS (hours) Depakote (Divalproex Sodium) (seizures) 500 mg - 1 tab PO TID (3 times a day) Oyster Shell Calcium with Vit (vitamin) D 500 mg/200 units - 1 tab PO daily Magnesium Oxide (supplement) - 800 mg daily." 06/2013: June 2013 MAR (Medication Administration Record) indicated client A received the following regarding the 8 PM Lamictal dose: 06/29, 30/13: Lamictal 100 mg at 8 PM 06/29, 30/13: Lamictal 200 mg at 8 PM 06/29, 30/13: Lamictal 100 mg at 8 PM For a total dose of Lamictal 400 mg at 8 PM on 06/29/13 and 06/30/13. The June 2013 contained the Lamictal 100 mg order on it twice. The hospital discharge order of 06/28/13 and the clarification of the order dated 06/28/13 indicated the total dose of the Lamictal was to be 300 mg. Client A received a total dose of Lamictal 400 mg on 06/29/13 and 06/30/13 and not the 300 mg as ordered. 06/2013: June 2013 MAR indicated client A was to start on Depakote 500 mg - 1 tab PO TID on 06/28/13. The medication doses were scheduled for 8 AM, 2 PM and 8 PM. The MAR			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	indicated client A did not receive the medication on 06/28/13 at 8 PM or on 06/29/13 at 8 AM for a total of 1000 mg in missed dosage. The MAR indicated the medication was "not sent" from pharmacy yet. 06/2013: June 2013 MAR indicated client A was to start on Dilantin (Phenytoin) (seizures) 200 mg tab PO Q 12 HRS (hours) on 06/28/13. The medication doses were were scheduled for 8 AM and 8 PM. The MAR indicated client A did not receive the medication on 06/28/13 at 8 PM or on 06/29/13 at 8 AM for a total of 400 mg in missed dosage. The MAR indicated the medication was "not sent" from pharmacy yet. 06/2013: June 2013 MAR indicated client A was to start on 06/28/13 at 8 PM two new medications which included: Oyster Shell Calcium with Vit (vitamin) D 500 mg/200 units - 1 tab PO daily Magnesium Oxide (supplement) - 800 mg daily. The MAR indicated client A did not receive the medications on 06/28/13 at 8 PM. The MAR indicated the medications were "not sent" from pharmacy yet. 06/2013: June 2013 MAR indicated client A was to start on Dilantin (Phenytoin) (seizures) 200 mg tab PO Q			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	12 HRS (hours) on 06/28/13 at 8 PM. The MAR indicated client A did not receive the medications on 06/28/13 at 8 PM or the 06/29/13 8 AM scheduled dose. The MAR indicated the medication was "not sent" from pharmacy yet. 06/29/13: Nursing notes indicated, "Followed up with pharmacy regarding delivery of Depakote and Dilantin. Dr [name] notified, no seizure activity." 07/02/13: Doctor Visit Form indicated client A was seen by his physician for follow-up of his seizures as per the hospital discharge instructions. The form indicated the Dr ordered the following medication change: "Reduce Dilantin to 100 mg - 1 am/2 pm for 3 days (300 mg daily); the 1 am/1 pm for three days; then 1 q hs (100 mg daily) times three days; then off." The order indicated client A was to have 100 mg of Dilantin in the AM and 200 mg of Dilantin in the PM for 3 days; then 100 mg in the AM and 100 mg in the PM for 3 days; then 100 mg at HS for 3 days then off. 07/02/13: Nurses notes by the LPN (Licensed Practical Nurse) indicated, "Client went to Dr [name] office for f/u (follow-up). Received new orders to taper off of Phenytoin (Dilantin). Group home staff informed. Will see Dr [name]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	again in 2 weeks." 07/2013: July 2013 MAR contained the hand written orders from the 07/02/13 Dr visit. The July 2013 MAR indicated the Dilantin reduction was started on 07/02/13. Client A received the following Dilantin doses: 07/02/13 - Dilantin 200 mg in the AM and 200 mg in the PM for a total dose of 400 mg. 07/03/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 300 mg. 07/04/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 300 mg. 07/05/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/06/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/07/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/08/13 - Dilantin 100 mg in the AM and 100 mg in the PM for a total dose of 200 mg. 07/09/13 - Dilantin 100 mg in the PM for a total dose of 100 mg. 07/10/13 - Dilantin 100 mg in the PM for a total dose of 100 mg. The July 2013 MAR did not follow the Dr			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/09/2013
NAME OF PROVIDER OR SUPPLIER AWS		STREET ADDRESS, CITY, STATE, ZIP CODE 55021 BIRCH RD 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
	orders for the Dilantin reduction. 07/03/13: Nurses notes by the LPN indicated, "Received call from [name], Dr [name] office that Vitamin D level is still low. Wants to change from the capsule to the liquid preparation for better absorption. To have Vit D level rechecked in 2 months. Order for Vit D preparation changed to liquid sent to [name] pharmacy electronically from Dr [name] office." 07/03/13: A "Comprehensive Physician's Order Sheet For: Telephone/Standing/Clarified Orders" dated 07/03/13 written by the LPN indicated, "Recheck Vit D level in 2 months. D/C Vitamin D capsule 500,000 U (unit) tablet. Give Engocalcifenol 4 ml (milliliter) once every week - Vitamin supplement." 07/2013: July 2013 MAR indicated client A received the first Vit D dose of the 07/03/13 order on 07/08/13. On 08/08/13 at 1:00 PM an interview was conducted with the Area Director (AD). The AD indicated client A's medications were changed when he was discharged from the hospital on 06/28/13, again on 07/02/13 and on 07/03/13. The AD indicated the MAR should correctly reflect those changes. She indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G713	(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	55021 BIRCH RD 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
	nurse should ensure the medications were in the home so the medications could be given as per the physician orders. She indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. This federal tag relates to complaint #IN00132685. 9-3-6(a)			