

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2014
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2331 CANDLEWICK DR FORT WAYNE, IN 46804
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(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
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: January 16, 17, 21, 22 and 23, 2014.</p> <p>Facility number: 004404 Provider number: 15G718 AIM number: 200510050</p> <p>Surveyor: Kathy Wanner, QIDP</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review completed 1/27/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000391	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review and interview, the facility failed to ensure medication was labeled for 1 of 4 routine medications administered to 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p>	W000391	All staff have received retraining on the Medication Administration Policy which states that all medications must be labeled. The Nurse, QDDP and manager have been completing a medication check sheet where they are checking that all medications are	02/22/2014

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>Observation of the 4:00 P.M. medication administration for client #1 was conducted at 4:15 P.M. on 1/21/14. Client #1 was administered 3 Tablespoons of Benefiber (fiber supplement) mixed in 8 ounces of water via client #1's G-Tube (gastrostomy tube). Client #1 was administered her other routine 4:00 P.M. medications via G-Tube at the same time. Client #1's container of Benefiber was not labeled with her name or the physician's order.</p> <p>Direct Care Staff (DCS) #1 was interviewed on 1/21/14 at 4:42 P.M. When asked if client #1's Benefiber was labeled, DCS #1 stated, "Yes, oh it doesn't have a label on it. There is usually a label on the top of the container, I will need to tell [name of Residential Manager]."</p> <p>Client #1's Physician's Order (PO) dated 12/1/13 was reviewed on 1/22/14 at 4:38 P.M. Client #1's PO indicated "Benefiber Powder give 3 tablespoons mixed with 8 oz (240 cc) water and flush per Mic (continuous feeding) Tube for constipation."</p> <p>The Residential Director (RD) was interviewed on 1/23/14 at 4:03 P.M. When asked if client #1's Benefiber</p>		<p>labeled. The check sheets will be turned into the director to monitor for compliance and will be ongoing to make sure unlabeled medications are labeled prior to being put in the medication cabinet. These will be completed weekly and will be ongoing.</p>				

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	<p>should have a label, the RD stated, "Yes, it was an oversight."</p> <p>9-3-6(a)</p>			