

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 11/23/2011
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2331 CANDLEWICK DR FORT WAYNE, IN46804
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 21, 22, 23, 2011.</p> <p>Provider Number: 15G718 Facility Number: 004404 AIM Number: 200510050</p> <p>Surveyors: Susan Reichert, Medical Surveyor III-Team Leader 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 was completed on 12/2/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
W0249	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.			

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>Based upon observation, record review, and interview, the facility failed to implement objectives included in Individual Support Plans (ISPs) and Behavior Support Plan (BSP) at formal and informal opportunities for 2 of 2 sampled clients (clients #1 and #2) and one additional client (client #3).</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 11/21/11 from 3:30 PM until 5:45 PM. On 11/21/11 from 3:45 PM until 4:41 PM and from 5:16 PM until 5:25 PM, medication administration was observed at the group home administered by staff #2.</p> <p>On 11/21/11 at 4:35 PM, staff #2 punched client #1's Risperdal (for behaviors), into a medication cup and put it into his mouth using a gloved hand. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>Client #1's records were reviewed on 11/22/11 at 10:00 AM. Client #1's ISP (Individual Support Plan) dated 08/11/11 contained a goal which indicated client #1 was to pop out one pill from the bubble pack.</p>	W0249	All staff have been re-trained on the clients ISP goals and the redirection strategies listed in the Behavior Support Plans. The nurse and management staff will complete medication pass observations with staff to ensure that ISP objectives are being implemented as well as redirection strategies for the Behavior Support Plans as needed. These observations will be documented on a Medication Observation Check list which will be monitored by the director for compliance. The management staff will also observe staff to ensure that the BSP intervention strategies and active treatment are being implemented throughout other activities in the home.	12/23/2011	

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	<p>On 11/22/11 at 2:35 PM an interview with the Program Director (PD) was conducted. The PD indicated client #1's medication administration should include training and objectives should have been implemented during medication administration.</p> <p>2. On 11/21/11 at 4:41 PM, staff #2 prepared client #2's Miralax (for constipation), into a measuring cup and put it into a cup filled with liquid and stir the contents. No teaching/training of the names, reasons, or doses of medication was observed.</p> <p>Client #2's records were reviewed on 11/22/11 at 10:30 AM. Client #2's ISP (Individual Support Plan) dated 03/01/11 contained a goal which indicated client #2 was to stir his Miralax powder.</p> <p>On 11/22/11 at 2:35 PM an interview with the Program Director (PD) was conducted. The PD indicated client #2's medication administration should include training and objectives should have been implemented during medication administration.</p> <p>3. At 3:45 PM client #3 was wheeled into the medication room. Client #3 was observed whine, wave her arms around and hitting the back of the door with the</p>				

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	<p>back of her hand approximately 13 times. Client #3's hand was red after the striking of her hand. During the time client #3 was hitting her hand, staff #2 stated several times, "stop bumping please" "come on" and "you need a potty break when we are done?" At 4:50 PM client #3 was taken to the bathroom. Client #3 could be heard hitting the wall in the bath room as she was attended to by staff #2.</p> <p>Client #3's records were reviewed on 11/22/11 at 1:00 PM. Client #3's ISP (Individual Support Plan) dated 07/01/11 contained a Behavior Support Plan (BSP) dated 07/01/11. The BSP indicated client #3's behaviors included, "Self Abusive Behavior, Refusals, Crying, and Physical Aggression." The BSP indicated, When [client #3] displayed self-injurious behaviors such as banging her head, wrist, or hand, staff should immediately redirect or reposition her without giving her any more verbal feedback or recognition of this behavior...If needed in order to prevent injury, staff should gently hold her hand to keep her from banging her wrist...".</p> <p>An interview was conducted on 11/22/11 at 2:35 PM with the Program Director (PD). The PD indicated staff should follow the BSP as written.</p>			

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	<p>4. Observations were conducted at the group home on 11/22/11 from 6:30 AM until 7:55 AM. During the breakfast meal, client #3 sat at the dining room table without activity from 6:30 AM until 6:50 AM while clients #1 and #2 ate breakfast. Client #3 cried and stomped her feet on her foot rests of her wheelchair. The QMRP (qualified mental retardation professional) asked to her to listen to the music video on the television in the adjacent room at 6:40 AM. Client #3 did not respond and continued to cry and stomp her feet or hit her hand on her wheelchair seven times, until she was given a Big Mac with recorded voices at 7:01 AM. Client #2 was fed by staff #4 during breakfast after client #2 failed to pick up his utensils without encouragement to use the utensils or other prompting to use his utensils by staff. After the breakfast meal client #2 sat in the living room next to a television showing a video with a maraca in his hand without using the maraca or being offered alternative activity from 7:10 AM until 7:55 AM.</p> <p>Client #2's record was reviewed on 11/21/11 at 8:50 AM. His ISP dated 3/1/11 included objectives to feed self 10 bites of food using utensils, participate in tactile sensory activities, complete range</p>			

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	<p>of motion exercises, and to activate a Big Mac switch to turn on a fan.</p> <p>Client #3's Behavior Support Plan (BSP) dated 7/1/11 included the target behaviors of self injurious behavior and crying. Interventions included the following for self injurious behavior: "It is important that staff monitor [client 33] to ensure that the behavior has ceased. If needed, in order to prevent injury, staff should gently hold her hand to keep her from banging her wrist. If this is not possible, staff should place a pillow or soft object between her head/hand and the object of her abuse. She should be encouraged to verbally indicate her needs or preference." For crying: "[client #3] begins to cry/whine, staff should respond with empathy. Often [client #3] cries when she wants to listen to music or bounce on the therapy ball. If a cause can't be determined within a few minutes, staff will provide [client #3] with a few choices of activities to participate in. This includes, listening to music, bouncing on the therapy ball, going outside (weather permitting), or playing with toys."</p> <p>The Residential Director was interviewed on 11/21/11 at 2:35 PM, and indicated client #2's objectives should have been implemented during formal and informal opportunities, and staff should have</p>						

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W0436	<p>implemented techniques in client #3's BSP.</p> <p>9-3-4(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 2 sampled clients, (client #2), the facility failed to ensure he was encouraged to use his adaptive equipment as per his individual support plan.</p> <p>Findings include:</p> <p>During observation at the group home on 11/22/11 from 6:30 AM until 7:55 AM, client #2 was feed by staff using a spoon with a straight built up handle during breakfast.</p> <p>Client #2's record was reviewed on 11/22/11 at 8:50 AM. His 3/1/11 Individual Support Plan (ISP) indicated he</p>	W0436	<p>A staff meeting was held and all staff have received additional training on the clients adaptive aids and involving the clients in food preparation, serving food once at the table and the assistance levels needed to assist the clients with eating. Dining checklist will be completed during mealtimes to ensure that appropriate equipment is being used. These forms will be completed by the management staff and monitored by the director to ensure compliance.</p>	12/23/2011	

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W0488	<p>was to use a bent, built up handled spoon and fork to aid with dining.</p> <p>The Residential Director was interviewed on 11/22/11 at 2:35 PM and indicated client #2 should have been encouraged to use a bent spoon/fork during meals.</p> <p>9-3-7(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 clients living in the group home (clients #1 and #2) by not ensuring the clients prepared their food or were encouraged to use dining skills as independently as possible.</p> <p>Findings include:</p> <p>1. On 11/21/11 from 3:30 PM until 5:45 PM observations at the group home were completed. On 11/21/11 at 4:52 PM, staff #1 was observed in the kitchen cooking supper and clients #1 and #2 were observed sitting at the dining room table playing a game. Staff #1 was observed to cook the entire meal by herself, puree</p>	W0488	<p>A staff meeting was held and all staff have received additional training on the clients adaptive aids and involving the clients in food preparation, serving food once at the table and the assistance levels needed to assist the clients with eating. Dining checklist will be completed during mealtimes to ensure that appropriate equipment is being used. These forms will be completed by the management staff and monitored by the director to ensure compliance.</p>	12/23/2011			

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	<p>food, set the table for clients #1 and #2 and take the serving dishes to the table. Clients #1 and #2 were observed at the table at 5:33 PM. Staff #1 and #2 were observed to scoop food onto the plates of clients #1 and #2 without client assistance. Client #1 was observed to eat independently and client #2's food was placed on his spoon and he was handed the spoon by staff #1. Clients #1 and #2 were not observed to participate in any aspect of preparing or serving the meal.</p> <p>Client #1's records were reviewed on 11/22/11 at 10:00 AM. Client #1's Comprehensive Functional Assessment (CFA) dated 08/11/11 indicated client #1 needed hand over hand assistance to serve food.</p> <p>Client #2's records were reviewed on 11/22/11 at 10:30 AM. Client #2's CFA dated 03/01/11 indicated client #2 needed hand over hand assistance to serve food.</p> <p>On 11/22/11 at 2:35 PM an interview with the Program Director (PD) was conducted. The PD indicated staff should have assisted clients #1 and #2 to prepare their own food as independently as they could.</p> <p>2. Observations were conducted at the group home on 11/22/11 from 6:30 AM.</p>				

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	<p>until 7:55 AM. Clients #1, and #2 were fed their breakfast meal by staff without encouraging clients #1 and #2 to feed themselves.</p> <p>Client #2's record was reviewed on 11/22/11 at 8:50 AM. His 8/29/11 nutritional report indicated he was able to feed himself with supervision and his Group Home Individual Support Plan Assessment dated 3/1/11 indicated he was able to feed himself with hand over hand assistance.</p> <p>Client #1's record was reviewed on 11/22/11 at 11:45 AM. His nutrition report dated 8/29/11 indicated client #1 was able to feed himself. His Group Home Individual Support Plan Assessment dated 8/11/11 indicated client #1 was able to feed himself and use utensils independently.</p> <p>The Residential Director was interviewed on 11/22/11 at 2:35 PM and indicated clients #1 and #2 should have been encouraged to feed themselves during meals.</p> <p>9-3-8(a)</p>				