

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 04/05/12</p> <p>Facility Number: 012562 Provider Number: 15G799 AIM Number: 201017540</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with smoke</p>	K0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
(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	
	<p>detection in the corridors, client sleeping rooms and common living areas. The facility has a capacity of 4 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.1.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/11/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
(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			
KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating person from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff no less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>1. Based on record review and interview, the facility administration failed to have a complete fire safety plan to protect 4 of 4 clients. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>During the record review process with the Group Home Manager on 04/05/12 at 1:48 p.m., the facility did have a written fire safety plan but the plan did not include the initiation of the fire alarm by staff</p>	KS147	<p>K0147 Incomplete fire safety plan Corrective action for resident(s) found to have been affected Plan has been updated to include the initiation of the fire alarm by staff. Regular staff meetings will now include review of instructions on safety plan – these meetings occur more frequently than every two months. Missing fire drill was conducted, and a new schedule has been implemented. How facility will identify other residents potentially affected & what measures taken All residents affected, and corrective action addresses the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Fire</p>	05/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
(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	
	<p>personnel in the event of an emergency. Based on an interview with the Group Home Manager at the time of record review, no other documentation was available for review.</p> <p>2. Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 4 of 4 clients. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of "Residential Safety Drill Report" documentation with the Group Home Manager on 04/05/12 at 1:25 p.m., lapses in staff fire safety training times were more than the two months allowed as evidenced by the lack of any training or Fire Drill record for the 7:00 a.m. to 3:00 p.m.</p>		<p>safety plan has been updated. Staff meetings now include review of plan. Drills conducted and on a schedule. How corrective actions will be monitored to ensure no recurrence The Group Home Manager supervises staff and monitors implementation of the fire safety plan and fire drills. The manager also holds regularly-scheduled staff meetings. The Director supervises the Group Home Manager and they meet regularly. Program implementation is monitored at these meetings with review of documented home visit forms.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940
---	--

(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
	shift during the first quarter of 2012. The Group Home Manager said at the time of record review, there was no other Fire Drill or other training documentation for this period.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
(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			
KS152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action; and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include: Based on review of the "Residential Safety Drill Report"</p>	KS152	<p>K0152</p> <p>Evacuation drills at least quarterly for every shift</p> <p>Corrective action for resident(s) found to have been affected</p> <p>An Evacuation Drill was conducted on the shift cited.</p>	05/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
(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	
	with the Group Home Manager on 04/05/12 at 1:25 p.m., fire drill documentation for the first shift of the first quarter of 2012 was not available for review. Based on an interview with the Group Home Manager at the time of record review, no other documentation was available for review.		<p>How facility will identify other residents potentially affected & what measures taken</p> <p>All residents affected, and corrective action addresses the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>A Drill schedule has been implemented to ensure that drills occur across shifts as required.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager is responsible to ensure that Drills are conducted as scheduled.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
(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			
KS154	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to protect 4 of 4 clients by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the "System Failure" documentation with the Group Home Manager on 04/05/12 at 1:48 p.m., the facility did have a written policy and procedure for an impaired sprinkler system but the policy did not indicate when an individual is conducting the fire watch, this</p>	KS154	<p>K0154 Staff conducting fire watch and other duties – sprinkler failure Corrective action for resident(s) found to have been affected Procedures have been amended. They now state that if sprinklers or smoke detectors fail, there will be 15 minute inspections, and the person responsible for completing them will have no other duties during that time. How facility will identify other residents potentially affected & what measures taken All residents affected, and corrective action addresses the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Fire watch procedures were updated to address cited deficiencies. How corrective actions will be monitored to ensure no recurrence The Group Home Manager supervises staff and monitors implementation of the fire safety plan. The Director supervises the Group Home Manager and they meet regularly.</p>	05/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	individual shall have no other duties or responsibilities. This was acknowledged by the Group Home Manager at the time of record review.		Program implementation is monitored at these meetings with review of documented home visit forms.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940			
(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			
KS155	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to protect 4 of 4 residents by providing a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the "System Failure" documentation with the Group Home Manager on 04/05/12 at 1:48 p.m., the facility did have a written policy and procedure for an impaired fire alarm system but the policy did not indicate when an individual is conducting the fire watch, this</p>	KS155	<p>K0155 Staff conducting fire watch and other duties – fire alarm Corrective action for resident(s) found to have been affected Procedures have been amended. They now state that if sprinklers or smoke detectors fail, there will be 15 minute inspections, and the person responsible for completing them will have no other duties during that time. How facility will identify other residents potentially affected & what measures taken All residents affected, and corrective action addresses the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence Fire watch procedures were updated to address cited deficiencies. How corrective actions will be monitored to ensure no recurrence The Group Home Manager supervises staff and monitors implementation of the fire safety plan. The Director supervises the Group Home Manager and they meet regularly.</p>	05/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2012
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 10633 S AMERICA RD LA FONTAINE, IN 46940		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	individual shall have no other duties or responsibilities. This was acknowledged by the Group Home Manager at the time of record review.		Program implementation is monitored at these meetings with review of documented home visit forms.		