

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2014
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 9228 W CR 950 N ELIZABETHTOWN, IN 47232
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: April 28, 29, 30 and May 1, 2014.</p> <p>Facility number: 012547 Provider number: 15G795 AIM number: 201017690</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed May 5, 2014 by Dotty Walton, QIDP.</p>	W000000	<p>Please note that a letter was sent from ISDH requesting some modifications to the POC. The electronic system was locked and would not allow these change to be made, so a fax was sent to Steve C. on 5/30/14. ISDH notified the facility that the survey had been unlocked on 6/2/14, so the same information that was previously faxed is being uploaded at this time.</p>	
W000149	<p>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 3 of 13 incident/investigative reports reviewed affecting clients #1, #2 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse.</p> <p>Findings include:</p>	W000149	<p>W 149 Staff Treatment of Clients: Did not prevent Client-to-Client Abuse Corrective action for resident(s) found to have been affected 5/23/14 – Letter from ISDH asking clarification: How was the training given to staff different than the training originally received that has proven ineffective? Original Response: All staff members will receive documented training on</p>	05/31/2014

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>A review of the facility's incident/investigative reports was conducted on 4/28/14 at 1:25 PM and indicated the following:</p> <p>1. On 10/1/13 at 5:30 PM, client #2 was hitting walls and doors. Client #1 opened his bedroom door and asked client #2 to stop. Client #2 yelled "no" and client #1 grabbed client #2's arm and backed him into the couch. As staff was attempting to release client #1's hold on client #2, client #4 pulled client #1's hand off of client #2. The Bureau of Developmental Disabilities Services (BDDS) report, dated 10/2/13, indicated, "Staff assessed [client #2] and found a couple of small bruises on [client #2's] arm, no abrasions or other medical care was needed at this time." The investigation, dated 10/7/13, indicated, "For allegations or suspicions of abuse, neglect or exploitation, the allegation has been: Substantiated."</p> <p>2. On 11/8/13 at 6:00 PM, client #1 grabbed client #2 after client #2 slammed his hand on the table causing client #1's drink to spill on client #1. The BDDS report, dated 11/9/13, indicated, in part, "Staff intervened immediately just as [client #1's] knee barely scraped [client #2's] forehead. The investigation, dated 11/11/13, indicated, in part, "It was reported by a staff that [client #2] became</p>		<p>prevention of client-to-client abuse, including keeping appropriate spacing between clients when they are engaged in maladaptive behavior. Instructor is certified in agency's de-escalation and physical intervention technique. Update: The de-escalation and intervention training that all staff receive on an annual basis is generic and applies to potential situations that one might encounter when working with any given client. The training conducted to address citations in the survey was client specific and included role play. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff training on prevention of client-to-client abuse. How corrective actions will be monitored to ensure no recurrence 5/23/14 – Letter from ISDH asking clarification: What is the frequency by which staff will be monitored to ensure compliance? Original Response: Group Home Managers supervise all Direct Support Staff (DSPs) and ensure that their training needs are met. The agency's Regional Director supervises the managers and meets with them regularly. During those meetings,</p>				

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	<p>impatient about waiting for his dinner to cool off, he punched the kitchen table causing [client #1's] milk to spill on [client #1]. At time (sic) [client #1] stood up as if he was going to get napkins and without warning grabbed [client #2] by the head and attempted to hit him in the head with his knee, staff intervened and attempted to block the impact, staff reported that [client #1's] knee barely came into contact with [client #2's] forehead, due to staff's hand being placed on [client #1's] leg." The investigation indicated, "For allegations or suspicions of abuse, neglect or exploitation, the allegation has been: Substantiated."</p> <p>3. On 11/13/13 at 5:00 PM, client #1 was eating supper with his roommates at the table. Client #4 was talking with staff when client #1 told him to shut up. Client #4 looked at him and said no one was talking to you. Client #1 slapped client #4 in the face, jumped up and punched client #4 in the head. Client #4 grabbed client #1's arms and pinned him against the wall telling him to calm down. Staff got in between the clients. Client #1 leaped over the top of the staff and quickly hit client #4 in the back of the head 4 more times. The investigation, dated 11/15/13, indicated, in part, "For allegations or suspicions of abuse, neglect or exploitation, the</p>		<p>staff training needs are reviewed, including monitoring of an "expiration report" that lists each DSP and his/her training deadlines. Update: The Group Home Manager completes home visit forms on a regular basis, and the Regional Director reviews these forms at their regular meetings. After training is complete, the Group Home Manager will complete at least one form that will include practicing the lessons learned in the training.</p>				

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	<p>allegation has been: Substantiated."</p> <p>A review of the facility's Group Home Abuse and Neglect policy, dated 8/08, was conducted on 4/28/14 at 3:12 PM. The policy indicated, in part, "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse. Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>On 4/30/14 at 11:34 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was considered abuse. The QIDP indicated an investigation was conducted and the interdisciplinary team meets to discuss the incidents. The QIDP indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The QIDP indicated the facility should prevent abuse of the clients. The QIDP stated, "We do what we can to prevent."</p> <p>9-3-2(a)</p>						

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 2 clients in the sample (#2), the facility failed to develop a plan to address client #2's clothes being stored in a closet in the common area of the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/28/14 from 3:53 PM to 5:32 PM and 4/29/14 from 6:51 AM to 9:17 AM. During the observations, client #2's clothes were stored in a closet in the main entrance hallway closet.</p> <p>A review of client #2's record was conducted on 4/29/14 at 10:24 AM. Client #2's Individual Support Plan (ISP), dated 10/1/13, and Behavior Support Plan (BSP), dated 12/12/13, did not include a plan to store client #2's clothes outside of his bedroom in a closet within staff's view. The facility did not provide documentation the interdisciplinary team discussed storing client #2's clothes in a closet outside of his bedroom.</p>	W000227	<p>W 227 Individual Program Plan: Client #2's clothing storage Corrective action for resident(s) found to have been affected Client #2's guardian requested that his clothing be kept in a closet outside his room so as to better monitor what he is wearing and provide him with appropriate direction as to dressing and toileting properly. The closet in question is unlocked, and he has free access to the clothing kept there. This restriction was added to his Behavior Support Plan (BSP) and has been submitted for Human Rights Committee (HRC) approval. How facility will identify other residents potentially affected & what measures taken This restriction only applies to this client. None of his housemates also has the restriction. Measures or systemic changes facility put in place to ensure no recurrence Restriction added to BSP and submitted for HRC approval. How corrective actions will be monitored to ensure no recurrence The Behavior Clinician (BC) is responsible for working with the Interdisciplinary Team (IDT) that includes Client</p>	05/31/2014			

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W000249	<p>On 4/29/14 at 12:01 PM, the Residential Manager (RM) indicated he was not sure if there was a plan to store client #2's clothes in the hallway closet. The RM indicated storing client #2's clothes in the hallway should be part of a plan.</p> <p>On 4/30/14 at 11:34 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2 had property destruction in his BSP. The QIDP indicated client #2's guardian requested client #2's clothes be stored in the hallway closet. The QIDP indicated client #2 would, if he had his clothes in his room, put on several layers of clothing and urinate on them. The QIDP indicated the closet where his clothes were stored was accessible, unlocked and in the view of the staff. The QIDP indicated storing his clothes in the hallway closet was discussed with the interdisciplinary team and should be included in a plan.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>		#2's guardian. In coordination with the IDT, the BC writes and implements the BSP, including restrictions. All restrictive measures are submitted to the HRC for approval. The BC is supervised by the agency's Regional Director, and they meet regularly. During those meetings, there is a standing item to address any emergent behavior issues in the home, which includes adjustments to the BSP.		

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	<p>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.</p> <p>Based on observation, record review and interview for 1 of 2 clients in the sample (#2), the facility failed to ensure staff implemented his program plan as written for wearing padded wrist bands during waking hours.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/28/14 from 3:53 PM to 5:32 PM and 4/29/14 from 6:51 AM to 9:17 AM. On 4/28/14 at 5:02 PM, client #2 hit the wall several times while breathing heavily. Client #2 was asking for his medicine over and over. Client #2 stated, after hitting the walls, "Stop pounding!" At 5:07 PM, client #2 continued to hit the walls and kicked the closet door three times. At 5:22 PM, client #2 hit the walls with his wrist near his bedroom. During the observations at the group home, client #2 was not wearing padded wrist bands during waking hours.</p> <p>A review of client #2's record was conducted on 4/29/14 at 10:24 AM. Client #2's Behavior Support Plan (BSP),</p>	W000249	<p>W 249 Program Implementation: Padded Wrist Bands Corrective action for resident(s) found to have been affectedThe padded wrist bands for Client #2 were originally in place due to his highly frequent maladaptive behavior that includes banging his wrists against the wall. As his behavior has gradually decreased over time, his need to wear the wrist bands has diminished. As a result of this, the Behavior Clinician (BC) has reduced the restrictive measure of wearing wrist bands in the Behavior Support Plan (BSP). Instead of requiring that they be worn during all waking hours, Client #2 now only needs to wear them if extensive bruising becomes evident. Because this change to the BSP represents a reduction in the restrictive measure, it was not submitted for Human Rights Committee approval.</p> <p>How facility will identify other residents potentially affected & what measures takenThis restriction only applies to this client. None of his housemates wears wrist bands.</p> <p>Measures or systemic changes facility put in place to ensure no</p>	05/31/2014			

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	<p>dated 12/12/13, indicated, in part, "As part of his SIB (self injurious behavior), [client #2] will bang the back of his wrist against walls and other hard objects, often causing bruising. To help protect his wrist from injury, he will wear padded wrist bands during waking hours." Client #2's Individual Support Plan, dated 10/1/13, indicated, in part, "He often exhibits self injurious behavior that results into self inflicted bruising on his wrist, hands, feet, legs and chest, staff should be aware of this and ensure injuries are appropriately recorded."</p> <p>On 4/29/14 at 12:03 PM, the Residential Manager (RM) stated "I believe it's still part of the plan" when asked if the padded wrist bands were part of the program plan. The RM indicated the padded wrist bands were to protect client #2's wrists from hitting and biting his own wrist.</p> <p>On 4/30/14 at 11:34 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #2 wearing his padded wrist bands was not current. The QIDP stated, "We don't enforce." The QIDP indicated the group home was not currently using the padded wrist bands but they remained in his plan in case they needed to go back to them. The QIDP indicated the behaviorist was responsible</p>		<p>recurrence Restrictive measure reduced in BSP.</p> <p>How corrective actions will be monitored to ensure no recurrence The Behavior Clinician (BC) is responsible for working with the Interdisciplinary Team (IDT) that includes Client #2's guardian. In coordination with the IDT, the BC writes and implements the BSP, including restrictions. All restrictive measures are submitted to the HRC for approval, but when a restrictive measure is reduced or discontinued, no HRC approval is sought. The BC is supervised by the agency's Regional Director, and they meet regularly. During those meetings, there is a standing item to address any emergent behavior issues in the home, which includes adjustments to the BSP.</p>				

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W000440	<p>for updating the BSP and the plan should be updated to reflect the discussion of the wrist bands being an option, not a requirement. The QIDP indicated the bands were put in place to address client #2 biting his wrist however biting had decreased.</p> <p>9-3-4(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to conduct quarterly evacuation drills during the staff's night shift (11:00 PM to 7:00 AM).</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 4/28/14 at 4:36 PM. During the night shift, there were no evacuation drills conducted from 10/5/13 to 4/8/14. This affected clients #1, #2, #3 and #4.</p> <p>On 4/29/14 at 12:01 PM, the Residential Manager (RM) indicated there should be quarterly drills during the night shift. The RM indicated night shift drills were</p>	W000440	<p>W 440 Evacuation Drills: Missing Night Shift Drills Corrective action for resident(s) found to have been affected The agency's 3rd shift staff have conducted a night evacuation drill and received a documented training on the need to follow the drill schedule that is kept in the home. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Night shift drill has been completed, and staff have been trained on need to follow drill schedule. How corrective actions will be monitored to ensure no recurrence Group</p>	05/31/2014			

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W009999	<p>scheduled on 10/28/13 and 2/10/14. The RM indicated the drills should have been conducted as scheduled.</p> <p>On 4/30/14 at 11:34 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated evacuation drills were required quarterly for each shift of personnel.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 10) Alleged, suspected, or actual criminal activity by an individual receiving services or an employee, contractor, or agent of a provider, when: a) the</p>	W009999	<p>Home Managers supervise all Direct Support Staff (DSPs) and ensure that their training needs are met. In addition, a monthly home audit is conducted in which completed drills are monitored. The agency's Regional Director supervises the managers and meets with them regularly. All home audits are sent to the Regional Director as well as the agency's Compliance Department, which reviews the audits to ensure that they are fully completed, including review of all applicable drills.</p> <p>W 9999 Final Observations: Agency did not complete a needed Incident Report (IR) Corrective action for resident(s) found to have been affected This was a rare event, and an error was made by the Regional Director and managers when this incident occurred because they did not believe it to be a reportable incident. They met and reviewed the need to report all similar incidents if a client is suspected of engaging in any criminal activity. In addition, an IR has been completed and uploaded to the state's electronic incident reporting platform. A copy of the IR was distributed to the Interdisciplinary Team (IDT). How facility will identify other residents potentially affected & what measures taken This</p>	05/31/2014			

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	<p>individual's services are affected or potentially affected; b) the activity occurred at a service delivery site or during service activities; or c) the individual was present at the time of the activity, regardless of location.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 10 Bureau of Developmental Disabilities Services (BDDS) incident reports reviewed affecting client #4, the facility failed to report to BDDS, in accordance with state law, an incident of client #4 stealing while at work causing him to lose his community-based employment.</p> <p>Findings include</p> <p>On 4/29/14 at 11:00 AM, a review of client #4's Behavior Summary Report, dated 3/1/14 to 3/31/14, indicated, in part, "In the month of March, [client #4] had no behavioral episodes documented. However he was fired from his job at [name of store], due to theft. The store will withhold the cost of items from his final pay as restitution and will turn over the information to the authorities, who will decide if further action will be taken. [Client #4] has requested counseling to</p>		<p>incident is specific to this client. All other incidents in the home were reported as required.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence IR completed and distributed. How corrective actions will be monitored to ensure no recurrence The Group Home Managers are responsible for completing IRs. They are supervised by the Regional Director who meets with them regularly. All IRs are distributed to the IDT and the Regional Director. An Incident Oversight Committee – comprised of the Regional Director, an agency Vice President, and a Compliance Officer – reviews all reported incidents and makes recommendations as needed.</p>		

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	<p>help deal with his compulsion to shoplift and a referral was made. His current job coach withdrew services and referrals to other agencies are being considered for employment services."</p> <p>A review of the facility's BDDS reports was conducted on 4/28/14 at 1:25 PM. The facility did not provide documentation the incident involving client #4 stealing from his employer and being fired was reported to BDDS.</p> <p>On 4/28/14 at 1:44 PM, the behaviorist indicated client #4 was fired from his community job due to stealing.</p> <p>On 4/30/14 at 11:34 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the incident was verbally reported to BDDS but not on a BDDS incident report. The QIDP indicated there was no police involvement. The QIDP indicated client #4 was fired from his job and the store indicated they may file charges in the future. The QIDP indicated the BDDS Service Coordinator was involved in a meeting to discuss the incident. The QIDP indicated client #4 admitted to stealing the items and then returned the items. The QIDP stated the incident would have been reported to BDDS "but there was no criminal involvement."</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G795	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/01/2014
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 9228 W CR 950 N ELIZABETHTOWN, IN 47232		
(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	
	9-3-1(b)				