

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G036	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 820 MENDLESON DR RICHMOND, IN 47374
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W0000	<p>This visit was for the annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/23/12, 7/24/12, 7/25/12, 7/26/12, and 8/1/12.</p> <p>Facility Number: 000596 Provider Number: 15G036 AIMS Number: 100233390</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/7/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0227	<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.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#2), the ISP (Individual Support Plan) and BSP (Behavior Support Plan) failed to address the client's identified behavioral needs.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/25/12 at 12:09 PM. Client #2's Electronic Health Record dated 4/6/11 indicated, "[Client #2] presents for examination and possible cleaning. [Client #2] has taken Xanax (Anxiety) as ordered and with her care staff. [Client #2] is nicely sedated and sits in operatory chair...." Client #2's Human Rights Approval Form dated 3/8/12 indicated the approval for Alprazolam/Xanax 0.5 MG (Milligram) one tablet, as needed for anxiety. Client #2's ISP dated 11/10/11 did not indicate medical or dental procedure desensitization training or supports. Client #2's BSP dated 7/20/10 did not indicate medical or dental procedure anxiety as a targeted behavior or include desensitization training or support.</p> <p>Interview with BC (Behavior Consultant) #1 on 7/26/12 at 11:00 AM indicated client #2 had dental and medical procedure anxiety related behaviors. BC #1 indicated client #2 had a PRN (As Needed) sedative for use during periods of anxiety. BC #1 indicated client #2 did not have a desensitization plan included in her BSP or ISP.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 7/26/12 at 11:10</p>	W0227	<p>Corrective actionfor resident(s) found tohave been affected The Behavior Clinician responsible for ensuring the Behavior Support Plan is in place, complete and accurate will update the BSP to include a desensitization plan for any consumer needing psychotropic medications for physician visits and will seek HRC approval. The QDDP responsible for programming will ensure the BSP is complete and accurate. Staff will be trained on all updated BSPs by the BC or a supervisor trained by the BC.</p> <p>How facilitywill identify otherresidents potentially affectedand what measures taken All residents with orders to receive psychotropic medications for physician visits are affected and corrective action will address the needs of all clients.</p> <p>Measures orsystemic changes facilityput in place toensure no recurrence Monitoring the BSP and physician orders will be added to the quarterly meeting agenda. The team including the BC, QDDP, and LPN will compare the physician orders to the BSP at</p>	08/31/2012			

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	AM indicated client #2 had dental and medical procedure anxiety. QMRP #1 indicated client #2's ISP and BSP did not address medical and/or dental procedure anxiety or desensitization training. 9-3-4(a)		each quarterly to ensure compliance. The QDDP is responsible for the meeting agenda. The LPN will update the BC with all psychotropic medication orders and the BC will update the BSP as needed and seek HRC approval. How correctiveactions will be monitoredto ensure no recurrence The QDDP will follow up to ensure the BC updates all BSPs and all staff are trained on all new or updated plans by the BC or a supervisor trained by the BC. The Regional Director will be sent the agenda following each consumer meeting by the QDDP to ensure compliance. The Regional Director will sign off, and will return the agenda to the QDDP to maintain in the client file.		

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation and interview for 2 of 4 sampled clients (#3 and #4) plus one additional client (#5), the facility failed to implement the clients' training objectives during formal and informal training opportunities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/25/12 from 6:15 AM through 7:45 AM. At 6:30 AM client #4 was prompted by staff #1 to come to the medication administration area. Client #4 came to the medication administration area and sat down. Staff #1 proceeded to administer client #4's morning medications. Staff #1 did not prompt or encourage client #4 to participate in the administration of his medicine. At 6:45 AM client #5 was prompted by staff #1 to come to the medication administration area. Client #5 came to the medication administration area and sat down. Staff #1 proceeded to administer client #5's morning medications. Staff #1 did not prompt or encourage client #5 to participate in the administration of his medicine. At 6:57 AM client #3 was prompted by staff #1 to come to the medication administration area. Client #3 came to the medication administration area and sat down. Staff #1 proceeded to administer client #3's morning medication. Staff #1 did not prompt or encourage client #3 to participate in the administration of his medication.</p>	W0249	<p>Corrective action for resident(s) found to have been affected Staff responsible for conducting training during medication pass will be trained. This training will include integrating active treatment into all teachable moments including all medication passes such as informing the client what the medication is for. The Team Leader or LPN will observe a medication pass monthly for all staff ensuring active treatment is present.</p> <p>How facility will identify other residents potentially affected and what measures taken All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence In addition to training the staff members responsible for the lack of training, all staff members will be trained. Staff will be told that even as goal documentation may not be necessary at all moments, any time of training will involve active treatment and teaching.</p>	08/24/2012			

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	<p>Staff #1 was interviewed on 7/25/12 at 6:50 AM. Staff #1 indicated the clients did not have medication administration training during the morning medication time.</p> <p>Client #3's record was reviewed on 7/25/12 at 12:36 PM. Client #3's ISP (Individual Support Plan) dated 11/9/11 indicated client #3 was not independent in administering his own medication. Client #3's ISP indicated client #3 had a training objective to repeat the names of his medications back to staff during the administration of his medication.</p> <p>Client #4's record was reviewed on 7/26/12 at 7:55 AM. Client #4's ISP dated 11/9/11 indicated client #4 was not independent in administering his own medication. Client #4's ISP indicated client #4 had a training objective to name his medications to staff during the administration of his medication.</p> <p>Client #5's ISP dated 11/9/11 was reviewed on 7/26/12 at 9:50 AM. Client #5's ISP indicated client #5 was not independent in administering his own medication. Client #5's ISP indicated client #5 had a training objective to repeat the names of his medications back to staff during the administration of his medication.</p> <p>Interview with nurse #1 on 7/26/12 at 10:04 AM indicated staff should be conducting informal and formal training with each client at each medication administration.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) was interviewed on 7/26/12 at 11:10 AM. QMRP #1 indicated staff should training clients at each available opportunity with formal and informal supports.</p>		<p>Training will involve the reminder that active treatment will be expected at each and every time of medication pass, such as informal discussion of what the medication is for. The Team Leader or LPN will observe a medication pass monthly for each staff to ensure active treatment is present.</p> <p>How correctiveactions will be monitoredto ensure no recurrence</p> <p>The Team Leader or LPN will observe a medication pass for each staff monthly to ensure active treatment is present. The LPN is responsible to ensure the medication observations are completed and turned in monthly. The QDDP is responsible for training all staff on active treatment. The Regional Director will sign off on all records of training ensuring all staff are trained.</p>				

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	9-3-4(a)			

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation and interview for 1 of 4 sampled clients (#3), the facility nurse failed to ensure staff followed medication administration guidelines.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/25/12 from 6:15 AM through 7:45 AM. At 6:57 AM client #3 was prompted by staff #1 to come to the medication administration area. Client #3 came to the medication administration area and sat down. Staff #1 proceeded to administer client #3's morning medication. Staff #1 administered two plastic spoon fulls of Lactulose (Stool softener) to client #3.</p> <p>Staff #1 was interviewed on 7/25/12 at 7:00 AM. Staff #1 indicated client #3's Lactulose was administered with two plastic spoonfuls. When asked if client #3's Lactulose was measured, staff #1 indicated he should receive a 30 milliliter dose at the AM medication pass.</p> <p>Interview with the facility nurse on 7/25/12 at 9:45 AM indicated staff were trained to administer liquid medications using a plastic measuring cup to ensure proper dosage. When asked if staff #1 could use a plastic spoon to administer client #3's Lactulose, nurse #1 stated, "That's not how [staff #1] was trained to do."</p> <p>9-3-6(a)</p>	W0331	<p>Corrective action for resident(s) found to have been affected</p> <p>All staff will be retrained on Medication Administration in a Core A Core B refresher course taught by the Group Home LPN. This medication administration training will include the appropriate way to pass medication and the appropriate way to measure liquid medication. The Team Leaders or LPN will observe one medication pass for each staff monthly.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The Team Leader or LPN will observe one medication pass for each staff monthly. This will ensure staff are continually passing medications as trained in Core A Core B.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required</p>	08/24/2012			

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			medication observations monthly. The Regional Director will ensure all Group Home staff receive this retraining and will sign off on all Record of Trainings.		

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W9999	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of in duration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled staff (staff #1) personnel records reviewed, the facility failed to obtain yearly PPD's and/or a chest x-ray and/or PPD screening checklist for employed staff.</p> <p>Findings include:</p> <p>Staff #1's personnel record was reviewed on 7/24/12 at 12:09 PM. Staff #1's personnel record indicated staff #1 last had a Mantoux test on 3/30/11. Staff #1's personnel file did not have a current chest x-ray or TB (Tuberculosis) checklist/screening to indicate the staff person was</p>	W9999	<p>Corrective action for resident(s) found to have been affected</p> <p>The staff found during survey with an expired TB test received her TB test on 7/27/12 and the results were placed in her HR file.</p> <p>How facility will identify other residents potentially affected and what measures taken</p> <p>All residents are affected and corrective action will address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>The HR Administrative Assistant will forward the Group Home Manager monthly the list of all expiration dates. The GHM is responsible to notify all staff of upcoming expiration dates. Staff will be trained that they will be suspended from working if all required tests are not current.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>HR Administrative Assistant will monitor and send to GHM monthly. GHM will monitor and notify staff monthly.</p> <p>The Regional Director will sign off on the record of training ensuring all staff are trained on necessity of keeping expiration dates current.</p>	08/24/2012			

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	<p>free of TB symptoms.</p> <p>Interview with Human Resource Coordinator (HRC) #1 on 7/24/12 at 1:00 PM indicated staff #1 had not received an annual TB testing. HRC #1 indicated there was no checklist or x-ray to review to document staff #1 was free of TB symptoms.</p> <p>9-3-3(e)</p>						