

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628
---	--

(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
W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: June 11, 12, 13, 14 and 24, 2013.</p> <p>Provider Number: 15G708 AIM Number: 200453440 Facility Number: 003834</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 5, 2013 by Dotty Walton, QIDP.</p>	W000000		

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:  15G708		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628			
(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			
W000249	<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, record review, and interview for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), the facility failed to ensure the clients received a continuous active treatment program by staff not implementing programs during training opportunities at the group home.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 6/11/13 from 5:45 A.M. until 8:00 A.M. During the observation, client #1 sat in her wheelchair in front of the television with no activity. Client #2 sat in a recliner with no activity. Client #3 sat in an arm chair with no activity. Client #4 sat in her wheelchair with no activity.</p> <p>An evening observation was conducted at the group home on 6/11/13 from 2:50 P.M. until 5:40 P.M. During the entire observation, client #3 sat in her wheelchair in front of the television</p>	W000249	<p>All staff have been retrained on the proper implementation of active treatment and goals and objectives identified in the ISP. The QDDP and Residential Manager will monitor active treatment on all shifts and will document that the staff have been observed providing continuous active treatment. These observations will be documented on a staff observation form and turned into the director for review.</p> <p>Addendum: The QDDP and Residential Manager will complete observations of staff three times on each shift to ensure that continuous active treatment and ISP goals are implemented. Monthly spot checks at various times will be completed monthly thereafter. These observations will be documented on a staff observation form and turned into the director so compliance can be monitored.</p>	07/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628			
(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>holding a children's musical toy with no activity. Client #1 sat in a recliner holding a television remote control in one hand with no activity. During the entire observation, clients #1, #2, #3 and #4 did not do fine/gross motor skills, physioroll (exercise), swing, vibrating mat, cleaning the tables, passing out shirt protectors, socialization skills and/or residential tasks (chores).</p> <p>A review of client #1's record was conducted on 6/12/13 at 5:10 P.M. A review of client #1's undated Active Treatment schedule indicated: "3:00 P.M.-4:15 P.M.: Psychomotor-fine/gross motor, physioroll (exercise), swing, vibrating mat...4:15 P.M.-6:30 P.M.-clean the tables, pass the shirt protectors, socialization, residential tasks (chores), socialization, pursuit of leisure."</p> <p>A review of client #2's record was conducted on 6/12/13 at 4:35 P.M. A review of client #2's undated Active Treatment schedule indicated: "3:00 P.M.-4:15 P.M.: Psychomotor-fine/gross motor, physioroll, swing, vibrating mat...4:15 P.M.-6:30 P.M.-clean the tables, pass the shirt protectors, socialization, residential tasks, socialization, pursuit of leisure."</p> <p>A review of client #3's record was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628		
(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>conducted on 6/12/13 at 5:10 P.M.. A review of client #3's undated Active Treatment schedule indicated: "3:00 P.M.-4:15 P.M.: Psychomotor-fine/gross motor, physioroll, swing, vibrating mat...4:15 P.M.-6:30 P.M.-clean the tables, pass the shirt protectors, socialization, residential tasks, socialization, pursuit of leisure."</p> <p>A review of client #4's record was conducted on 6/12/13 at 5:20 P.M. A review of client #4's undated Active Treatment schedule indicated: "3:00 P.M.-4:15 P.M.: Psychomotor-fine/gross motor, physioroll, swing, vibrating mat...4:15 P.M.-6:30 P.M.-clean the tables, pass the shirt protectors, socialization, residential tasks, socialization, pursuit of leisure."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:10 A.M. The RD stated "Each client has an active treatment schedule and staff should implement them at all times of opportunity."</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628		
(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	
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 2 sampled clients (client #2), and 2 additional (clients #3 and #4), the facility failed to assure the staff provided food in accordance with the clients' diet orders.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 6/11/13 from 5:45 A.M. until 8:00 A.M. At 7:00 A.M., Group Home Trainer (GHT) #4 took containers out of the refrigerator and placed them on the table. The containers were labeled and indicated they held meals consisting of eggs, toast and ham. At 7:15 A.M., clients #1, #2, #3 and #4 began eating their breakfast. The eggs and ham were not of a pureed consistency.</p> <p>A review of client #2's record was conducted on 6/12/13 at 4:35 P.M. Review of client #2's most current Nutritional Assessment dated 4/25/13 indicated: "Pureed diet."</p> <p>A review of client #3's record was conducted on 6/12/13 at 5:10 P.M.</p>	W000460	<p>All staff have received retraining on the preparation of modified diets and have completed return demonstrations to ensure that the training has been effective. The manager and QDDP will complete spot checks to ensure that staff have implemented their training. These checks will be documented on the Dining Skills Checklist and will be turned into the director for review and to monitor compliance. Addendum: The management staff will complete three meal observations on each shift then monthly spot checks will be completed thereafter to ensure that foods are modified to the proper consistency. These observations will be documented on a dining checklist form and turned into the director so compliance can be monitored.</p>	07/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628		
(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>Review of client #3's most current Nutritional Assessment dated 4/25/13 indicated: "Pureed (diet consistency)."</p> <p>A review of client #4's record was conducted on 6/12/13 at 5:20 P.M. Review of client #4's most current Nutritional Assessment dated 4/25/13 indicated: "Pureed diet."</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:10 A.M. The RD indicated staff should have followed each client's prescribed diet.</p> <p>9-3-8(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628
---	--

(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
--------------------	--	---------------	---	----------------------

W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE</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 and interview, the facility failed to ensure 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4) were involved in meal preparation and served themselves at meal times as independently as possible.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 6/11/13 from 5:45 A.M. until 8:00 A.M. At 7:00 A.M., clients #1, #2, #3 and #4 sat at the dining table with no activity as Group Home Trainer (GHT) #4 took food containers out of the refrigerator and placed them onto the table. The containers were labeled and indicated the meal they held consisted of eggs, toast and ham. At 7:15 A.M., clients #1, #2, #3 and #4 began eating their breakfast. Clients #1, #2, #3 and #4 did not assist in meal preparation. At 7:30 A.M., labeled, plastic containers of prepared food were observed in the refrigerator which indicated: "Lunch: cold meat and cheese sandwich (sic), pasta salad and pears; Dinner: Tuna caserole (sic), spinach and dinner roll."</p> <p>An interview with GHT #4 was</p>	W000488	<p>All staff received additional training on the clients ability to participate in meal preparation as determined by their assessments. Spot checks are being completed by the management staff to ensure that this training has been effective. The management staff are completing Dining Observation Checklists at various meals to document their observations, note areas of retraining if needed and these checklist are monitored by the director to ensure compliance.</p> <p>Addendum: The management staff will complete three meal observations on each shift then monthly spot checks will be completed thereafter to ensure client participation with meal preparation including serving of the meal as independently as possible. These observations will be documented on a dining checklist form and turned into the director so compliance can be monitored.</p>	07/24/2013
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/24/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628			
(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>conducted on 6/11/13 at 7:35 A.M. GHT #4 indicated the labeled, clear plastic containers were clients #1, #2, #3 and #4's already prepared food for the day. GHT #4 indicated the overnight staff prepares all meals for all clients.</p> <p>An evening observation was conducted at the group on 6/11/13 from 2:50 P.M. until 5:40 P.M. During the observation period, clients #1, #2, #3 and #4 sat in the living room with no activity. At 5:00 P.M., GHT #6 took several containers filled with prepared blended food out of the refrigerator and placed them into the microwave oven. The containers were labeled and indicated the meal consisted of Tuna casserole, spinach and dinner roll. At 4:45 P.M., clients #1, #2, #3 and #4 ate their already prepared dinner. Clients #1, #2, #3 and #4 did not assist in meal preparation.</p> <p>An interview with the Residential Director (RD) was conducted on 6/14/13 at 11:10 A.M. The RD indicated clients were capable of assisting in meal preparation and of serving themselves with assistance and further indicated they should be assisting in preparation and serving themselves with assistance at meal time.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAST FOX TR SOUTH BEND, IN 46628
---	--

(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
	9-3-8(a)			