

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/05/2013
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/2, 7/3, and 7/5, 2013.</p> <p>Facility number: 003799 Provider number: 15G705 AIM number: 200447350</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/15/13 by Ruth Shackelford, 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.

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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 1 of 2 sampled clients (Client #1) and one additional client (Client #3) who had Dysphagia Care Plan/Mealtime Guidelines, the facility failed to ensure the dining plans were implemented.</p> <p>Findings include:</p> <p>1) On 7/2/13 between 4:02 PM and 6:37 PM, group home observations were conducted. Between 5:12 PM and 6:10 PM, dinner preparations and serving were observed. At 5:43 PM, Direct Support Professional (DSP) #2 was observed assisting Client #1 with eating dinner. Client #1 was observed to be sitting in a gravity tilt wheelchair tilted at approximately a 30 degree angle. DSP #2 was observed to assist Client #1 with bringing his food to his mouth on a spoon as Client #1 was observed to have limited physical control of his arms and hands due to involuntary movements. Client #1 was observed to cough throughout his dining time. Client #1 was observed to begin coughing at 5:43 PM. Client #1 was observed to continue to cough while drinking skim milk through a straw at 5:48 PM. Client #1 was observed to cough again at 6:00 PM and between 6:02 PM to 6:03 PM. At 6:03 PM, DSP #3 was observed to adjust the tilt of Client #1's chair to its most upright position which positioned</p>	W000249	<p>All staff will receive re-training on the mealtime guidelines and proper positioning of all clients. They will also be re-trained on the interventions included in each client's plan and their responsibilities should a client exhibit triggers as indicated in the plan. In order to ensure that their training was effective, post-tests will be completed and the management staff and the nurse will conduct observations of all staff during a meal. Observations will be documented and turned into the director for review.</p> <p>Addendum: The management staff and the nurse will complete three meal observations on each shift then monthly spot checks will be completed to ensure that mealtime guidelines and proper positioning are being implemented. These observations will be documented on a dining checklist form and turned into the director so compliance can be monitored.</p>	08/04/2013			

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	<p>Client #1 at a 45 degree angle. At 6:07 PM, Client #1 was observed to have completed dinner but continued to cough loudly in long intervals which were unproductive in clearing his throat.</p> <p>On 7/3/13 at 12:37 PM, record review for Client #1 indicated the client's diagnoses included, but were not limited to, profound intellectual disabilities, cerebral palsy with spasticity/contractures, GERD (gastroesophageal reflux disease), large hiatal hernia, esophagitis, osteoporosis, constipation, megacolon, scoliosis, and incontinence.</p> <p>Client #1's "Nursing Assessment" dated 4/12/13 indicated Client #1 was on a pureed diet and had "exhibited dysphagia triggers in past 12 months." The Nursing Assessment indicated "[Client #1] has wheezing due to asthma with symptoms increasing when he is agitated or excited. He needs frequent positioning for optimal inspiration/expiration of air. Repositioning is essential along with monitoring him closely for increased symptoms of respiratory difficulty of coughing and wheezing. Feeding him in an upright position and allowing adequate time for swallowing are important in maintaining respiratory health."</p> <p>Client #1's annual nursing report dated 4/14/13 indicated Client #1 "receives a pureed diet, nectar thickened liquids with 8 oz (ounce) of skim milk, 4 oz prune juice every breakfast and dinner, Magic Cup with breakfast and dinner." The annual nursing report indicated Client #1 "does need to be positioned upright to prevent coughing with possible aspiration. Positioning needs to be monitored during the meal and he should be repositioned as needed for easier swallowing." The annual nursing report indicated "Nursing Care Plans" which included nursing plan #2 to "provide</p>						

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	<p>nutritious diet. Monitor food preparation and ensure proper consistency. Assist in developing mealtime guidelines and overseeing implementation to prevent aspiration."</p> <p>During record review, Client #1's "Mealtime Guidelines" dated April 2013 were reviewed. Client #1's mealtime guidelines indicated staff should "have [Client #1] properly positioned comfortably in his wheelchair and in a more upright position." The mealtime guidelines indicated staff should "see Positioning guidelines." Client #1's mealtime guidelines indicated "if [Client #1] coughs, stop feeding him and allow him to clear his throat and relax. Reposition him, wait before giving another bite or drink." The mealtime guidelines indicated "if [Client #1] continues to cough after he is done eating, reposition him and check his temperature and oxygen levels. Call the nurse to report findings."</p> <p>Client #1's "Positioning" guideline dated 4/14/13 indicated "[Client #1] is non-ambulatory, unable to bear weight and requires a two-man lift for all transfers. [Client #1] has contractures of both knees in a flexed position, and increased tone to the hips. Both of [Client #1]'s legs are fixed in a position with his knees swayed to the left and his feet coming back to the right. [Client #1] has a custom molded wheelchair. Due to his spasticity and increased extensors tone, he is extremely difficult to get into the proper position and maintain the position. He requires the use of a 4 point pelvic positioning belt due to his extensive tone which results in his hips thrusting forward and he slides out of the chair." Client #1's positioning guidelines indicated "prior to and during meals he needs to be monitored for good positioning. His wheelchair needs to be as upright as possible and he may need slight assistance with maintaining his head upright and forward."</p>			

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	<p>On 7/3/13 at 1:11 PM, the Residential Director/Registered Nurse (RD/RN) indicated Client #1 should be positioned in his most upright position while eating and Client #1's wheelchair positioning guide should have been used by staff to position Client #1 as indicated during mealtime.</p> <p>2) On 7/3/13 group home observations were conducted between 6:15 AM and 8:42 AM. Between 6:42 AM and 7:33 AM, preparation and serving of breakfast were observed. At 6:57 AM, Direct Support Professional (DSP) #1 was observed to assist Client #3 with breakfast. DSP #1 was observed to feed with total assistance by scooping up Client #3's food with a spoon and bringing it to his mouth. Client #3 was observed moving his head back and forth to avoid the spoon. At 7:07 AM, Client #3 was observed blocking DSP #1's effort to bring the spoon to his mouth by bringing up with left arm. DSP #1 was observed to hold Client #3's left arm down while attempting to place the spoon in Client #3's mouth. Client #3 was observed to continue to move his head from side to side to avoid the spoon when DSP #1 was observed to hold Client #3's forehead, pressing his head to the wheelchair head rest, to persuade Client #3 to eat the spoonful of food. At 7:14 AM, Client #3 was observed to continue to move his head back and forth evading the feeding spoon while he began to vocalize. When Client #3 was observed to open his mouth and vocalize, DSP #1 was observed to put the food in Client #3's mouth.</p> <p>Record review on 7/5/13 at 2:30 PM included Client #3's "Annual Nursing Report" dated 2/15/13 which indicated Client #3 "is eating his pureed diet well. He may have a PRN (given as needed) feeding (by gastro-intestinal tube) after meal if he consumes less than 50% of his oral diet</p>				

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	<p>but this is rare that he requires it. He is doing well with this current nutritional plan."</p> <p>Review of Client #3's "Mealtime Guidelines" dated May 2013 indicated "[Client #3] is on a pureed diet and receives supplemental tube feeding." The guidelines indicated staff should "place a spoon in his hand and ask [Client #3] to scoop his food and eat." The guidelines indicated "breakfast is [Client #3]'s favorite meal. Assist [Client #3] to feed himself at this time with as much independence as possible. He does not eat lunch and supper so well, and will tend to refuse his meals by turning his head away from the food." The guidelines indicated staff should give Client #3 choices of what he wants to eat by trying various food items. The guidelines indicated "staff will alternate in trying to get [Client #3] to eat." The guidelines indicated "...[Client #3] takes time to swallow, and staff should give him as much time to complete his swallowing process." The guidelines indicated "if [Client #3] continues to refuse his meals, rubbing his cheeks gently sometimes will provide stimulation for him to open his mouth. This is another way to get him to eat."</p> <p>On 7/3/13 at 1:11 PM during an interview, the Residential Director/Registered Nurse indicated staff should have followed Client #3's mealtime guidelines while assisting him during breakfast.</p> <p>9-3-4(a)</p>				

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W000267	<p>483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.</p> <p>Based on observation, interview, and record review, the facility failed to implement written policies and procedures for the management of conduct between staff and clients for 1 of 2 sampled clients (Client #2) and 2 additional clients (Clients #3 and #4).</p> <p>Findings include:</p> <p>1) On 7/3/13 group home observations were conducted between 6:15 AM and 8:42 AM. Between 6:42 AM and 7:33 AM, preparation and serving of breakfast were observed. At 6:57 AM, Direct Support Professional (DSP) #1 was observed to assist Client #3 with breakfast. DSP #1 was observed to feed with total assistance by scooping up Client #3's food with a spoon and bringing it to his mouth. Client #3 was observed moving his head back and forth to avoid the spoon. At 7:07 AM, Client #3 was observed blocking DSP #1's effort to bring the spoon to his mouth by bringing up with left arm. DSP #1 was observed to hold Client #3's left arm down while attempting to place the spoon in Client #3's mouth. Client #3 was observed to continue to move his head from side to side to avoid the spoon when DSP #1 was observed to hold Client #3's forehead, pressing his head to the wheelchair head rest, to persuade Client #3 to eat the spoonful of food. At 7:14 AM, Client #3 was observed to continue to move his head back and forth evading the feeding spoon while he began to vocalize. When Client #3 was observed to open his mouth and vocalize, DSP #1 was observed to put the food in Client</p>	W000267	<p>Client #3 will be assessed by the RD/RN to clearly define that plan needed to ensure that client #3 receives adequate nutrition. Client #3 has significant spasticity which requires staff to physically guide his hands to complete tasks. Client #4 will also be assessed by the RD/RN to clearly define that plan needed to ensure that client #4 receives adequate hydration. Appropriate interventions will be developed by the IDT and reviewed by the Human Rights Committee to ensure that the benefit outweighs the restriction. The dietician will also review the guidelines that are developed after assessment. Once defined and pending approval of the IDT, guardian and HRC, staff will be trained on the needed restrictions to assist client #3 and #4. The Residential Director will ensure all the training has been completed once the comprehensive plan has been developed and approved. Additionally, all staff have received re-training on the Staff and Client Interaction Policy, the Client Rights Policy and the Confidentiality Policy. Staff will be monitored by the house manager and QDDP to ensure that their training was effective and these</p>	08/04/2013
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	<p>#3's mouth.</p> <p>On 7/3/13 at 1:11 PM during an interview, the Residential Director/Registered Nurse indicated staff should have followed Client #3's mealtime guidelines while assisting him during breakfast.</p> <p>Record review on 7/5/13 at 2:30 PM included Client #3's "Annual Nursing Report" dated 2/15/13 which indicated Client #3 "is eating his pureed diet well. He may have a PRN (given as needed) feeding (by gastro-intestinal tube) after meal if he consumes less than 50% of his oral diet but this is rare that he requires it. He is doing well with this current nutritional plan."</p> <p>Review of Client #3's "Mealtime Guidelines" dated May 2013 indicated "[Client #3] is on a pureed diet and receives supplemental tube feeding." The guidelines indicated staff should "place a spoon in his hand and ask [Client #3] to scoop his food and eat." The guidelines indicated "breakfast is [Client #3]'s favorite meal. Assist [Client #3] to feed himself at this time with as much independence as possible. He does not eat lunch and supper so well, and will tend to refuse his meals by turning his head away from the food." The guidelines indicated staff should give Client #3 choices of what he wants to eat by trying various food items. The guidelines indicated "staff will alternate in trying to get [Client #3] to eat." The guidelines indicated "...[Client #3] takes time to swallow, and staff should give him as much time to complete his swallowing process." The guidelines indicated "if [Client #3] continues to refuse his meals, rubbing his cheeks gently sometimes will provide stimulation for him to open his mouth. This is another way to get him to eat."</p> <p>2) On 7/3/13 between 7:40 AM and 8:50 AM,</p>		<p>observations of staff interactions will be documented and turned into the director so compliance can be monitored.</p> <p>Addendum: The house manager and QDDP will complete observations of staff interactions three times on each shift to ensure that plans and policies are followed. Monthly spot checks will be completed thereafter. These observations will be documented on a staff observation form and turned into the director to monitor for compliance.</p>				

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	<p>morning medication administration was observed. At 8:15 AM, DSP #1 was observed to assist Client #2 with his medication administration. After DSP #1 had assisted Client #2 with his medication administration, DSP #1 was observed to encourage Client #2 to drink water from a sippy cup. Client #2 was observed to refuse holding the cup himself two times after which DSP #1 put the cup up to Client #2's mouth. While DSP #1 was assisting Client #2 with drinking his water by holding his cup to his mouth and tipping it, the DSP #1 said "He [Client #2] can hold a cup and give himself a drink, but he is just lazy. That's how he is." While Client #2 continued to be assisted in holding his cup of water, DSP #1 said, "[Client #2], you are lazy but you are a good guy."</p> <p>During an interview on 7/3/13 at 1:11 PM, the RD/RN indicated use of language such as "lazy" to describe a client is not tolerated by the facility.</p> <p>3) At 8:34 AM, DSP #1 assisted Client #2 out of the medication room by assisting him by pushing his wheelchair into the kitchen. While DSP #1 was assisting Client #2 into the kitchen, DSP #4 was standing next to Client #3 at the dining room table. Client #3 who is non-verbal began to make vocalizations and outstretch his arms. DSP #4 was observed to ask Client #3 if he wanted something to drink. In response, DSP #1 said "That sound means he's pooping. Pooping is his job." DSP #1 was observed to say this in the presence of Clients #1, #2, #3, and #4 and DSP #4 and DSP #5.</p> <p>4) At 8:38 AM, DSP #1 was observed to assist Client #4 with medication administration. DSP #1 was observed to attempt to give Client #4 his medication while Client #4 pursed his lips and refused. DSP #1 was observed to press Client #4's head to the head rest by holding his forehead with his hand while he attempted to give Client #4's</p>						

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	<p>medication on a spoon with applesauce. DSP #1 was observed to hold Client #4's forehead in place two more times while he attempted to assist Client #4 with drinking his water. DSP #1 was observed to hold Client #4's water cup to his mouth. Client #4's mouth was observed to be open but when DSP #1 tipped the cup, Client #4 spit the water back out or made bubbles. After two minutes of encouraging Client #4 to drink his water, DSP #1 tipped the water cup which filled Client #4's mouth with water. Client #4 began to swallow the water but a good portion flowed out of his mouth from both corners of his mouth onto Client #4's shirt protector.</p> <p>On 7/5/13 at 11:54 AM, the RD/RN was interviewed and stated DSP #1 was "nervous" during his interactions with clients during observations but his treatment of the clients was against policy and she would follow through accordingly.</p> <p>The facility's undated "AWS Procedure for Staff/Client Interactions" was received by the RD/RN as current on 7/5/13 at 1:49 PM and reviewed. The procedure indicated staff should speak in a respectful tone and no use of "terms derived from disability categories will be allowed, i.e. 'retard, dummy, low grade, stupid, idiot, etc'." The procedure indicated "when it is necessary to give a person feedback on a negative aspect of their behavior, the staff needs to be careful to work their comments in such a way as to center on the behavior and not the worth of the person." The procedure indicated "we are completely and firmly committed to the principle that persons who are treated with dignity and respect will learn to respond to others with concern for their dignity and respect."</p> <p>On 7/5/13 at 1:49 PM, the facility's "Rights and</p>						

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	Responsibilities of the Individuals Receiving Services" dated 2004 was received from the RD/RN. The policy indicated individuals have the right to "receive services in a safe, secure, and supportive environment" and "be treated with consideration, dignity and respect, free from mental, verbal, emotional and physical abuse, neglect, maltreatment, exploitation and retaliation."  9-3-5(a)						

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W000474	<p>483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client.</p> <p>Based on observation, record review, and interview, the facility failed to ensure clients received food consistent with physician orders in regards to the texture of pureed foods for 1 of 2 sampled clients (Client #1) and one additional client (Client #4).</p> <p>Findings include:</p> <p>On 7/2/13 between 4:02 PM and 6:37 PM, group home observations were conducted. At 5:20 PM, the Medication Administration Records (MARs) dated 7/13 for Clients #1 and #4 were reviewed and indicated both clients had physician orders for pureed diets.</p> <p>Between 5:12 PM and 6:10 PM, dinner preparations and serving were observed. Clients #1 and #4 were observed to receive a pureed diet. The pureed meat was observed in the family style serving bowl to contain a gritty texture with small lumps of meat throughout. Clients #1 and #4 were observed to receive the pureed meat from the family style serving bowl.</p> <p>At 5:38 PM, Client #4 began to cough while eating the pureed meat given hand</p>	W000474	<p>The guide for modifying food has been updated to include acceptable consistencies of meat. Pureed meat will however, have some texture to it. If the clients did not like the texture, the meat could have been pureed with other food items or a substitution could have been offered. Staff will receive training on the updated guide for modifying food which will include the option to modify multiple foods together to change the texture or making substitutions if needed. Staff will complete a return demonstration to ensure that they understand their options when modifying food.</p> <p>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>	08/04/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/05/2013
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	<p>over hand staff assistance. At 5:48 PM, Client #4 was observed to have a coughing spell during which he appeared to suck residue back into his throat while taking a breath. Client #4 was then observed to throw up food and liquids onto his shirt protector.</p> <p>At 5:43 PM, Direct Support Professional (DSP) #2 was observed assisting Client #1 with eating dinner. Client #1 was observed to be sitting in a gravity tilt wheelchair tilted at approximately a 30 degree angle. DSP #2 was observed to assist Client #1 with bringing his food to his mouth on a spoon as Client #1 was observed to have limited physical control of his arms and hands due to involuntary movements. Client #1 was observed to cough throughout his dining time. Client #1 was observed to begin coughing at 5:43 PM when given the pureed meat. Client #1 continued to cough until the pureed meat sprayed out of his mouth outward onto the floor. Client #1 was observed to continue to cough while drinking nectar thickened skim milk through a straw at 5:48 PM. Client #1 was observed to cough again at 6:00 PM and between 6:02 PM to 6:03 PM. At 6:03 PM, DSP #3 was observed to adjust the tilt of Client #1's chair to its most upright position which positioned Client #1 at a 45 degree angle. At 6:07 PM,</p>				

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	<p>Client #1 was observed to have completed dinner but continued to cough loudly in long intervals which were unproductive in clearing his throat.</p> <p>On 7/3/13 at 1:11 PM, interview with the Residential Director/Registered Nurse (RD/RN) indicated staff should have followed facility guidelines for modified diet consistencies.</p> <p>On 7/5/13 at 1:45 PM, the staff guideline for "How to Prepare Pureed /Mechanically Soft Food" (undated) received from the RD/RN as current was reviewed and indicated staff should "puree the food until it is the consistency of mashed potatoes or pudding...". The guidelines did not distinguish acceptable texture differentiations between types of meat being pureed.</p> <p>On 7/5/13 at 3:37 PM, the RD/RN was interviewed and indicated Client #1 ate smoked sausage, green bean and potato casserole with biscuit and fruit jello on the evening of 7/3/13 for dinner. The RD/RN stated sausage can be "stringy" when pureed. The RD/RN indicated Client #4 has not been sensitive to textures and she didn't believe the texture of the pureed sausage would have been the cause of his coughing. The RD/RN indicated if a client has an issue tolerating</p>						

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	a texture of a pureed item, staff should have offered an alternative or should have taken it off the menu for next time.  9-3-8(a)			