

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G787	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2013
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804
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W000000	<p>This visit was for the investigation of complaint #IN00129909.</p> <p>Complaint #IN00129909: Substantiated. Federal/state deficiencies related to the allegation are cited at W192.</p> <p>Dates of Survey: June 6, 10, 12, 13, 14 and 17, 2013.</p> <p>Facility number: 012483 Provider number: 15G787 AIM number: 201011380</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed June 20, 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.

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A) to ensure staff correctly implemented training protocol for choking as written during a choking incident.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/6/13 at 4:02 PM. A report dated 5/27/13 indicated client A had been eating her lunch which included steak cut into 1/2 inch pieces. Staff heard client A "make a noise and appear to be trying to cough to get something out, but was unable to." The report indicated staff initiated the Heimlich Maneuver and the other staff called 911 and staff initiated CPR until the paramedics arrived. Client A was admitted to the hospital and placed on a ventilator until a neurologist recommended due to the lack of brain activity, client A be removed from the ventilator. Client A was removed from the ventilator and died on 5/30/13. The report indicated client A did not require a</p>	W000192	<p>W192- AWS would like to formally appeal this citation. According to staff statements and notes taken during the interviews we believe that the staff followed their CPR training. According to the statement taken from staff #1 who seems to have the more reliable account of the events that day, she assisted client A to stand while her coworker began the Heimlich. This was due to the client's short stature, her body type and her dependence on a walker. She stated she helped the client stand and then ran to get the phone. As she got to the phone to call 911, staff #2 said she was tired and could not continue. At that point she had a client call the manager while staff #2 called 911. In our assessment of this incident, all protocols were followed based on the variables presented to the staff. Additionally as our timeline indicates, this was a matter of seconds.</p> <p>W192- All staff will receive a refresher to the CPR protocol indicating when to call 911 during a choking incident. Staff will be given post-tests to ensure their</p>	07/17/2013			

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	<p>dining plan, and had no dysphagia issues. "According to the initial interviews, staff followed proper protocol as taught in the American Red Cross curriculum for CPR (Cardio -Pulmonary Resuscitation)."</p> <p>The Residential Director was interviewed on 6/6/13 at 4:10 PM and indicated staff #1 had started the Heimlich Maneuver immediately when they realized client A was choking; when staff #1 tired, staff #2 took over and staff #1 called 911. Paramedics arrived within 4 minutes and had trouble removing anything but a small amount of steak and were unable to remove the remaining steak with suction.</p> <p>Staff #1 was interviewed on 6/6/13 at 5:35 PM. Staff #1 stated client A's steak was cut into 1/2 inch pieces and "was very tender." She indicated client A made a noise like she was clearing her throat during the meal. She indicated no back blows were given to client A and she had initiated the Heimlich Maneuver approximately 8 times after client A placed her hands around her throat as though she was choking. Staff #1 indicated staff #2 took over administering the Heimlich when she (staff #1) tired. Staff #1 indicated she then called 911 after staff #2 administered 2 Heimlich Maneuver attempts without dislodging the food. Staff #1 stayed on the phone with</p>		<p>understanding of the protocol. These tests will be reviewed by the director to verify compliance.</p>				

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	<p>911 staff while staff #2 continued the Heimlich Maneuver and then started CPR when client A lost consciousness and slipped to the floor. Paramedics arrived and transported client A to the hospital. She indicated the paramedics were able to retrieve a piece of food from client A's throat; but were unable to completely remove the blockage from client A's throat.</p> <p>Client C was interviewed on 6/6/13 at 5:54 PM. Client C indicated client A didn't have her dentures in on the day she choked. She indicated client A had choked in the past "about 2 months ago." She indicated when client A choked on 5/27/13 she (client C) had called the House Manager first and then called the QIDP (Qualified Intellectual Disabilities Professional). She indicated staff #2 had called the house manager on the house phone. She indicated staff #1 had called 911.</p> <p>The Residential Director was interviewed on 6/6/13 at 6:10 PM and indicated client A's dentures were new and client A had not been wearing them. She indicated there had been no reports of previous choking episodes for client A per interviews with staff.</p> <p>The facility's 2011 American Red Cross</p>						

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	<p>First Aid/CPR/AED (Automate External Defibrillator) used to train their staff was reviewed on 6/7/13 at 10:40 AM. The curriculum indicated, "Signals of choking include: coughing, either forcefully or weakly, clutching the throat with both hands, inability to cough, speak, cry or breathe, making high pitched noises while inhaling or noisy breathing, panic, bluish skin color, losing consciousness if blockage is not removed. When to call 911: If the person continues to cough without coughing up the object, have someone call 911 or the local emergency number. A partially blocked airway can quickly become completely blocked. A person whose airway is completely blocked cannot cough, speak, cry or breathe. Sometimes the person may cough weakly or make high-pitched noises. This tells you that the person is not getting enough air to stay alive. Act at once! If a bystander is available, have him or her call 911 or the local emergency number while you begin to give care. What to do when help arrives. If the choking person is coughing forcefully, let him or her try to cough up the object. A person who is getting enough air to cough or speak is getting enough air to breathe. Stay with the person and encourage him or her to continue coughing. A conscious adult or child who has a completely blocked airway needs immediate care. Using</p>			
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	<p>more than one technique is often necessary to dislodge an object and clear a person's airway. A combination of 5 back blows followed by 5 abdominal thrusts provides an effective way to clear the airway obstruction....For a choking person in a wheelchair, give abdominal thrusts."</p> <p>Documents from the mortality review packet being prepared were reviewed on 6/7/13 at 10:45 AM. A statement dated 5/28/13 written by staff #1 indicated staff #1 heard client A "trying to clear her throat. I looked over at [client A] her hands was (sic) @ (at) her throat appeared to be choking and [client C] had said she was choking." The statement indicated staff #2 had client A stand up and staff #1 indicated she "Immediately started Heimlich. I did Heimlich until I became tired (sic) did approximately 10 abdominal thrusts and the other staff took over. I called 911 and stayed on the phone with giving 911 information to the other staff is still doing Heimlich (sic) client was turning blue in face. Staff eased (sic) client to the floor. [Staff #2] started CPR." A statement dated 5/28/13 written by staff # 2 indicated, "I heard [client A] make a noise...She was appearing to cough to get something up. My self (sic) and other staff ran to and immediately started heimlich (sic)...[Staff #1] gave the Heimlich approximately 5-6</p>				

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	<p>times. (sic) during this time I grabbed the phone off the table and dialed [house manager] and handed the phone to [client C]. (sic) told to tell [house manager]. At this time [client A] is still gasping for air and still appear (sic) to be choking." Staff #2 indicated staff #1 tired and staff #2 switched places and she (staff #2) continued the Heimlich Maneuver while staff #1 called 911. Client A "collapsed" to the floor and staff #2 started CPR after listening for her breathing which was really shallow." Staff #2 looked in client A's airway to see if there was anything blocking her airway, but was unable to see anything blocking the airway.</p> <p>Client A's record was reviewed on 6/7/13 at 10:46 AM. A Monthly Report for Nutrition Services dated 3/13 indicated client A "is able to feed herself with staff supervision." A Group Home Nursing Assessment dated 4/6/13 indicated client A can "always" cut food, judge amount of food/liquid to be put into mouth, can chew food well, can swallow without difficulty...." The assessment did not indicate the need for a dining plan. There were no documented reports of previous choking incidents involving client A. A dental report dated 4/25/13 indicated client A was missing her upper teeth and 9 bottom teeth. An Addendum to the ISP (Individual Support Plan) dated 4/26/13</p>				

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	<p>indicated client A had been seen for dentures; for an exam, consultation and x-rays for a bottom partial denture, for cosmetic reasons. The addendum indicated "client A did not want to go forward with the bottom partial because she has always lived without them." Client A had been explained the benefits of wearing the dentures and client A "finally agreed." When client A was given the dentures, she stated they were very uncomfortable and she removed them and said she didn't want to wear them. The addendum indicated staff were to offer client A her bottom partials daily.</p> <p>The report from the ambulance arriving at the scene for client A on 5/27/13 was reviewed on 6/7/13 at 10:48 AM indicated the call was received at 12:23 PM and the ambulance arrived at 12:27 PM. The initial assessment indicated "Airway Completely Obstructed." The reported indicated at 12:30 PM a "large" piece of steak was removed with forceps.</p> <p>The Residential Director and Regional Director were interviewed on 6/7/13 at 10:50 AM. The Regional Director indicated staff are taught to use the instructions for a person in a wheelchair when a client uses a walker which is what client A required for mobility. The Regional Director indicated the facility</p>				

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	<p>had just received the ambulance report and planned to interview the paramedics to determine the size of steak retrieved from client A's throat as part of their investigation. She indicated client A's dentures were for cosmetic purposes and were never introduced for dining purposes.</p> <p>An e-mail from the Regional Director dated 6/10/13 at 12:11 PM (reviewed 6/10/13 12:15 PM) indicated the paramedics had been interviewed and described the piece of steak retrieved from client A's throat as "probably closer to 1 inch."</p> <p>Statements from the house manager were reviewed on 6/12/13 at 9:30 AM. The house manager indicated she had received a call from client C on client C's cell phone at 12:30 indicating staff #2 required help because client A was choking.</p> <p>A statement from the Qualified Intellectual Disabilities Professional (QIDP) was reviewed on 6/12/13 at 9:35 AM. She indicated she had received a cell phone call from client B's cell phone at 12:26 PM indicating she needed to get there (the facility) immediately because client A was choking. Client A indicated staff #1 was on the phone with 911 staff</p>			

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	<p>at that time.</p> <p>The group home nurse was interviewed on 6/13/13 at 12:30 PM. When asked if staff had implemented the American Red Cross curriculum correctly when they started the Heimlich Maneuver first before calling 911, she indicated the curriculum was to be used as a guide. She stated, "It happened so quickly," and indicated there was a short period of time between the initiation of the Heimlich Maneuver and staff calling 911. She stated, "each situation is different. I hate to comment since I wasn't there."</p> <p>This federal tag relates to complaint #IN00129909.</p> <p>9-3-3(a)</p>				