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 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AWS	5515 TOMAHAWK TR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for the investigation of complaint #IN00109369. Complaint #IN00109369: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W122, W149 and W153. Dates of Survey: June 7, 8, 2012. Facility number: 012483 Provider number: 15G787 AIM number: 2010118380A Surveyor: Susan Reichert, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/13/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to protect 1 of 4 sampled clients (client A) from abuse by staff. Findings include: 1. Please see W149. The facility neglected to implement written policy and procedures to protect 1 of 4 sampled clients (client A) from abuse by staff. 2. Please see W153. The facility failed to report 1 of 1 allegations of abuse involving client A to a law enforcement agency. This federal tag relates to complaint #IN00109369. 9-3-2(a)	W0122	See Plan of Correction for W149 and W153	07/08/2012

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W0149	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, the facility neglected to implement written policy and procedures to protect 1 of 4 sampled clients (client A) from abuse by staff, and failed to report 1 of 1 allegation of abuse involving client A to a law enforcement agency. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/7/12 at 3:51 PM. A report dated 6/1/12 indicated on 5/31/12 staff #1 reported to the residential director (RD) and to the QMRP (qualified mental retardation professional) that staff #2 had physically abused client A. After investigation, it was determined after becoming angry because she didn't want to get up for work client A had thrown orange juice at staff #2. Staff #2 put her hand on client A's neck and "shoved her backwards. [Client A] hit the edge of the doorway and went to the ground. The staff who witnessed the incident (staff #1) called and reported it immediately." The report indicated staff #2 was immediately suspended and	W0149	The staff person who failed to implement the Abuse and Neglect Policy has been terminated from their position with AWS. All staff have been retrained on the Abuse and Neglect policy and received additional training on the Elder Justice Act. Staff were administered post tests to ensure their training had been effective and they understood the material presented. The clients have also received additional training on reporting abuse and neglect. The professional staff are completing additional monitoring and spot checks to ensure that all training is being implemented. These checks are being documented and are reviewed by the director.	07/08/2012

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	client A was provided emotional support. The nurse assessed client A and found redness to client A's neck, redness on her right cheek and small scratches on her back. Client A was taken to her primary care physician (PCP) for assessment. Upon assessment by the PCP, the red areas had faded and were "barely" visible, client A's range of motion was within normal limits and client A had no complaints of pain. The report indicated the allegation of physical abuse was substantiated based upon the consistency of client and staff statements of the account of the incident and the staff person remained suspended and would be terminated. All staff were to receive competency based retraining on the agency abuse and neglect policy and management staff will conduct unannounced visits to the home and document findings on home visit forms. The RD was interviewed on 6/7/12 at 4:01 PM and indicated the allegation of abuse had been substantiated based upon witness statements. She indicated staff #2 had indicated in her statement she had restrained client A by crossing her arms and backing her into a wall and client A lost her balance and fell. The RD indicated staff #2's actions were in direct violation of agency policy, implementation of training staff #2 had			

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	received, and in violation of client A's behavior plan. She indicated staff #2 had been terminated. An investigation dated 6/4/12 into the 5/31/12 incident was reviewed on 6/7/12 at 4:01 PM and indicated "The allegation of physical abuse was substantiated based on the consistency of client and staff statements of the account of the incident." Client A's record was reviewed on 6/7/12 at 4:24 PM. Client A's Behavior Support Plan (BSP) dated 10/31/11 included target behaviors of physical aggression and verbal aggression. The plan did not include physical intervention to address the client's behavior. The RD was interviewed again on 6/7/12 at 4:28 PM and indicated client A did not have physical intervention in her plan, and the intervention staff #2 had used was considered abuse. She indicated there was no indication as to why staff #2 had reacted physically to client A and the agency planned to retrain staff on their policy and procedures regarding abuse and neglect and provide additional training for staff to recognize signs of potential abuse by staff. When asked if she had reported the allegation of abuse to a law enforcement agency, she indicated she had reported it to adult protective			

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	services on 6/1/12 who then reported it to the police on 6/2/12. Client A was interviewed on 6/7/12 at 5:45 PM. Client A indicated staff #2 had pulled the sheets from her while client A was in bed and client A had thrown orange juice on staff #2. She indicated staff #2 had put her hands around her neck and pushed her down. Client A indicated no other staff in the home had exhibited mistreatment toward her. Clients D and H were interviewed on 6/7/12 at 5:50 PM. Client D indicated she had witnessed the incident between client A and staff #2 on 5/31/12 and had provided a statement detailing the incident. Clients D and H indicated no other staff had exhibited mistreatment to the clients. Client B was interviewed on 6/7/12 at 6:00 PM. She indicated she had witnessed the incident on 5/31/12 and had provided a statement. She indicated no other staff had exhibited mistreatment to the clients, but indicated she had observed staff #2 pull the sheets from client C in the past. She indicated she was aware of staff she could report mistreatment to should it occur in the future. The facility's Group Home Abuse and			

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	Neglect policy dated 8/08 was reviewed on 6/8/12 at 10:00 AM and indicated "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse," and "If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protective Services, and client representatives...Other entities may need to be notified depending upon from which program the client is receiving services." A Memorandum dated June 17, 2011 from Centers for Medicaid Services reviewed on 6/7/12 at 10:00 AM indicated in part, "Section 1150 B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility." This federal tag relates to complaint			

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	#IN00109369. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to report 1 of 1 allegation of abuse involving client A to a law enforcement agency. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 6/7/12 at 3:51 PM. A report dated 6/1/12 indicated on 5/31/12 staff #1 reported to the residential director (RD) and to the QMRP (qualified mental retardation professional) that staff #2 had physically abused client A. The report was marked NA (not applicable) for notification of police. The report indicated the allegation of physical abuse was substantiated based upon the consistency of client and staff statements of the account of the incident and the staff person remained suspended and would be terminated. The RD was interviewed on 6/7/12 at 4:01 PM and indicated the allegation of	W0153	The staff person who failed to implement the Abuse and Neglect Policy has been terminated from their position with AWS. All staff have been retrained on the Abuse and Neglect policy and received additional training on the Elder Justice Act. Staff were administered post tests to ensure their training had been effective and they understood the material presented. The clients have also received additional training on reporting abuse and neglect. The professional staff are completing additional monitoring and spot checks to ensure that all training is being implemented. These checks are being documented and are reviewed by the director.	07/08/2012

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	abuse had been substantiated based upon witness statements. An investigation dated 6/4/12 into the 5/31/12 incident was reviewed on 6/7/12 at 4:01 PM and indicated "The allegation of physical abuse was substantiated based on the consistency of client and staff statements of the account of the incident." Client A's record was reviewed on 6/7/12 at 4:24 PM. Client A's Behavior Support Plan (BSP) dated 10/31/12 included target behaviors of physical aggression and verbal aggression. The plan did not include physical intervention. The RD was interviewed again on 6/7/12 at 4:28 PM and indicated she had reported it to adult protective services on 6/1/12 who then reported it to the police on 6/2/12. A Memorandum dated June 17, 2011 from Centers for Medicaid Services reviewed on 6/7/12 at 10:00 AM indicated in part, "Section 1150 B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed			

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	against a resident of that facility." This federal tag relates to complaint #IN00109369. 9-3-2(a)			