

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/26/2012
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NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7004 HOLDEN DR FORT WAYNE, IN 46835
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W0000	<p>This visit was for the investigation of complaint #IN00117587.</p> <p>Complaint #IN00117587- SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W104, W111, W149, W192, W341, W382, W456 and W474.</p> <p>Dates of survey: October 22, 23, 24, 25 and 26, 2012.</p> <p>Facility number: 012625 Provider number: 15G803 AIM number: 201023250</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/7/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise operating direction over the facility to ensure 6 of 8 clients living in the home (clients A, B, C, D, F and H) were provided a sanitary environment which promoted and provided for their health and safety.</p> <p>Findings include:</p> <p>1. Please refer to W149: The governing body neglected to follow their policy on Abuse and Neglect for 4 of 4 sampled clients (clients A, B, C, and D) and 2 additional clients (clients F and H) by neglecting to prevent ongoing infestation of scabies and lice; and by a day program staff failing to initiate emergency care for 1 of 4 sampled clients (client A) who choked at the facility owned/operated day program.</p> <p>2. Please refer to W341: The governing body failed to ensure the facility nursing services implemented appropriate preventative and instructive health measures to prevent the ongoing infestation of scabies and/or lice for 4 of 4 sampled clients (clients A, B, C and D)</p>	W0104	The Residential Director will be providing monitoring as listed in W149, W341, and W456. Please see those citation responses for specific monitoring.	11/25/2012			

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	<p>and 2 additional clients (F and H).</p> <p>3. Please refer to W456: The governing body failed to implement successful corrective actions to prevent the ongoing infestation of scabies and/or lice for 4 of 4 sampled clients (clients A, B, C and D) and 2 additional clients (F and H).</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-1(a)</p>				

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W0111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on record review and interview, the facility failed to ensure nursing notes were maintained documenting the history of diagnoses, treatments, outcomes and follow-up for 4 of 4 sampled clients (clients A, B, C and D) and 2 additional clients (F and H) who had ongoing infestation of scabies and/or lice.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 9/13/12 for 9/12/12 at 6:00 P.M. indicated "On 9/12/12 he (client A) was taken to [Name of Hospital #1's] ER (emergency room) for evaluation of a red area on his left knee. He was determined to have MRSA (Methicillin resistant Staphylococcus aureus) and given a dose of IM (intra-muscular) antibiotics. He was also diagnosed with scabies. He was given a steroid shot and</p>	W0111	All nurses have received additional training to ensure that the client's Health Issues/Nurses Notes accurately and completely document the history of the diagnoses, treatments, outcomes and follow ups for any diagnosed medical conditions. The Residential Director will monitor and review the monthly Health Issues/Nurses Notes monthly for compliance and at regular house visits.	11/25/2012	

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	<p>prescribed Permethrin (pyrethrins for scabies treatment) 5% (five percent) cream and Artrax (sic) (antihistamine) to counter itching symptoms. [Client A] was discharged from the ER. He has been treated with the prescription cream. His clothing and bedding have all been laundered in hot water as directed. All furniture and floors have been vacuumed. The AWS scabies protocol was implemented."</p> <p>Client A's record was reviewed on 10/23/12 at 2:10 P.M.. Client A's nursing notes indicated the following: "9/13/12 Med's. (medication) started...skin rash treated per orders. Client tolerated well...9/9/12 Rash over body, manager made an appointment, encouraged to continue lotion by RX (prescription), 8/2/12...Rash remains continue to use lotion [name of doctor] does not feel it is scabies thinks it is a dermatitis from prior treatment. 7/28/12 Checked and treated for lice. Order from [name of doctor] received...6/27/12 New rash (sic) and itching all over will address c/ (with) [name of doctor] tomorrow at visit...5/22/12 Rash remains called [name of doctor] new lotion ordered...5/16/12 Rash remains but continues to dry...5/9/12 Rash remains...5/4/12 Skin rash remains...5/3/12 ...skin rash." The BDDS report dated 9/13/12 indicated his</p>			

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	<p>rash was diagnosed as scabies and treated with Permethrin cream. Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS (hour of sleep) tonight then again in 7 (seven) days." The RN's nursing notes did not include all diagnoses, treatments and outcomes to determine what skin condition client A had, what medications were used, and what the outcome was or when/if client A's skin condition was resolved.</p> <p>Client B's record was reviewed on 10/23/12 at 2:28 P.M.. Client B's nursing notes indicated the following: "9/1/12 [client B] has a rash itching all over. Had staff make an appointment /c [name of doctor]...7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/30/12 indicated "Treatment for lice as instructed by doctor okay." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." A doctor's appointment form dated 9/13/12 indicated client B was diagnosed with scabies and treated with Permethrin Cream. The RN's nursing notes did not include all diagnoses, treatments and outcomes to determine what skin condition client B had, what medications were used, and what the</p>			

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	<p>outcome was or when/if client B's skin condition was resolved.</p> <p>Client C's record was reviewed on 10/23/12 at 2:51 P.M.. Client C's nursing notes indicated the following: " 7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' (over the counter) medication" Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." The RN's nursing notes did not include all diagnoses, treatments and outcomes to determine what skin condition client C had, what medications were used, and what the outcome was or when/if client C's skin condition was resolved.</p> <p>Client D's record was reviewed on 10/23/12 at 3:12 P.M.. Client D's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified....5/23/12 Rash to bilateral (upper) ext. (extremities). Called [name of dermatologist] for lotion...will use as directed." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication." Client D's MAR (medication administration record) dated for May 2012 indicated she was treated with Permethrin Cream on 5/24/12</p>						

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	<p>and 5/31/12. The RN's nursing notes did not include all diagnoses, treatments and outcomes to determine what skin condition client D had, what medications were used, and what the outcome was or when/if client D's skin condition was resolved.</p> <p>Client F's record was reviewed on 10/23/12 at 3:25 P.M.. Client F's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Order obtained per [name of doctor] guardian notified..." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication." The RN's nursing notes did not include what medications were used, and what the outcome was or when/if client F's lice infestation was resolved.</p> <p>Client H's record was reviewed on 10/23/12 at 3:43 P.M.. Client H's nursing notes indicated the following: "9/3/12...'itching skin' DX (diagnosis) Scabies will tx (treat) per orders. Steroid shot given per [name of doctor's nurse] and anti itch med's. (medication)...7/28/12 Checked and treated for lice. Order received from [name of doctor] guardian notified....7/18/12 ...Client continues to scratch at head and arms has scratch marks. No rash seen. Encouraged staff to utilize his lotions that were</p>			

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	<p>ordered...5/22/12 Rash remains...called in for lotion....5/4/12 Skin remains with rash...." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." The RN's nursing notes did not include all diagnoses, treatments and outcomes to determine what skin condition client H had, what medications were used, and what the outcome was or when/if client H's skin condition was resolved.</p> <p>Confidential interview A stated, "I thought there would have been more details written in the nursing notes as far as diagnosis and treatments."</p> <p>Confidential interview B stated, "It would normally all be written in the nursing notes."</p> <p>An interview was conducted with a facility LPN on 10/25/12 at 3:58 P.M.. The LPN stated, "Every time rash is written in the nursing notes we (the RN or one of the LPN's) completed a hands on assessment, we checked everyone."</p> <p>An interview was conducted with the Residential Director (RD) on 10/25/12 at 3:55 P.M.. The RD stated, "We followed the scabies protocol, we treated everyone who had any symptoms, even if the doctor</p>			

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	<p>did not diagnose them with scabies. We called the doctor and informed him we had a confirmed positive scabies in the house, which was a staff, and got the doctor recommendations to be proactive so we could treat everyone." The RD stated, "Not every time rash is written in the nursing notes was it scabies or head lice. Several of the clients have other skin conditions." The RD indicated the nursing notes did not always have corresponding diagnoses/treatment listed for each time rash was listed in the notes, but usually there was a corresponding physician's order, medical form, or the MAR to refer to.</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-1(a)</p>			

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W0149	<p>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 follow their policy on Abuse and Neglect for 4 of 4 sampled clients (clients A, B, C, and D) and 2 additional clients (clients F and H) by neglecting to prevent ongoing infestation of scabies and lice; and by a day program staff failing to initiate emergency care for 1 of 4 sampled clients (client A) who choked at the facility owned/operated day program.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>1. A BDDS report dated 9/13/12 for 9/12/12 at 6:00 P.M. indicated "On 9/12/12 he (client A) was taken to [Name of Hospital #1's] ER (emergency room) for evaluation of a red area on his left knee. He was determined to have MRSA (Methicillin resistant Staphylococcus aureus) and given a dose of IM (intra-muscular) antibiotics. He was also</p>	W0149	AWS does have a policy and protocol for lice and scabies treatment. Any outbreaks will be reported to the director who will ensure that all protocols are followed as written. All nurses have received additional training on the scabies and lice protocols and the specific nurse responsible has received counseling for her failure to obtain a second opinion when the clients rashes were not relieved by the prescribed treatment. Should this type of incident recur, the director will monitor all scripts and client status weekly to ensure effective treatment. All direct support staff have received additional training on appropriate texture modifications. The management staff are conducting spot checks at the day service to ensure that correct modification is being made to clients food. This is being documented on the dining skills checklist which is being monitored by the director for compliance. All the clients primary care physician's have examined the clients and have provided statements that clients are free and clear of scabies and lice.	11/25/2012			

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	<p>diagnosed with scabies. He was given a steroid shot and prescribed Permethrin (pyrethrins for scabies treatment) 5% (five percent) cream and Artrax (sic) (antihistamine) to counter itching symptoms. [Client A] was discharged from the ER. He has been treated with the prescription cream. His clothing and bedding have all been laundered in hot water as directed. All furniture and floors have been vacuumed. The AWS scabies protocol was implemented."</p> <p>Client A's record was reviewed on 10/23/12 at 2:10 P.M.. Client A's nursing notes indicated the following: "9/13/12 Med's. (medication) started...skin rash treated per orders. Client tolerated well....9/9/12 Rash over body, manager made an appointment, encouraged to continue lotion by RX (prescription), 8/2/12...Rash remains continue to use lotion [name of doctor] does not feel it is scabies thinks it is a dermatitis from prior treatment. 7/28/12 Checked and treated for lice. Order from [name of doctor] received...6/27/12 New rach (sic) and itching all over will address c/ (with) [name of doctor] tomorrow at visit....5/22/12 Rash remains called [name of doctor] new lotion ordered....5/16/12 Rash remains but continues to dry....5/9/12 Rash remains...5/4/12 Skin rash remains...5/3/12 ...skin rash." The</p>			

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	<p>BDDS report dated 9/13/12 indicated his rash was diagnosed as scabies and treated with Permethrin cream. Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS (hour of sleep) tonight then again in 7 (seven) days."</p> <p>Client B's record was reviewed on 10/23/12 at 2:28 P.M.. Client B's nursing notes indicated the following: "9/1/12 [client B] has a rash itching all over. Had staff make an appointment /c [name of doctor]...7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/30/12 indicated "Treatment for lice as instructed by doctor okay." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." A doctor's appointment form dated 9/13/12 indicated client B was diagnosed with scabies and treated with Permethrin Cream.</p> <p>Client C's record was reviewed on 10/23/12 at 2:51 P.M.. Client C's nursing notes indicated the following: " 7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' (over the counter) medication" Physician's orders dated</p>						

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	<p>5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>Client D's record was reviewed on 10/23/12 at 3:12 P.M.. Client D's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified....5/23/12 Rash to bilateral (upper) ext. (extremities). Called [name of dermatologist] for lotion...will use as directed." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication." Client D's MAR (medication administration record) dated for May 2012 indicated she was treated with Permethrin Cream on 5/24/12 and 5/31/12.</p> <p>Client F's record was reviewed on 10/23/12 at 3:25 P.M.. Client F's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Order obtained per [name of doctor] guardian notified..." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication."</p> <p>Client H's record was reviewed on 10/23/12 at 3:43 P.M.. Client H's nursing notes indicated the following: "9/3/12...'itching skin' DX (diagnosis) Scabies will tx (treat) per orders. Steroid shot given per [name of doctor's nurse]"</p>						

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	<p>and anti itch med's. (medication)...7/28/12 Checked and treated for lice. Order received from [name of doctor] guardian notified....7/18/12 ...Client continues to scratch at head and arms has scratch marks. No rash seen. Encouraged staff to utilize his lotions that were ordered...5/22/12 Rash remains...called in for lotion....5/4/12 Skin remains with rash...." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>An interview was conducted with the Residential Director (RD) on 10/25/12 at 3:55 P.M.. The RD stated, "We followed the scabies protocol, we treated everyone who had any symptoms, even if the doctor did not diagnose them with scabies. We call the doctor and informed him we had a confirmed positive scabies in the house, which was a staff, and got the doctor recommendations to be proactive so we could treat everyone." The RD stated, "Not every time rash is written in the nursing notes was it scabies or head lice. Several of the clients have other skin conditions such as psoriasis, allergic dermatitis, we even thought [client A] had an allergy to vinyl or a medication reaction." The RD on 10/22/12 at 3:15 P.M. stated, "They (scabies/lice) were brought into the house</p>						

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	<p>by staff. We have terminated two staff."</p> <p>Employee Disciplinary Reports for Direct Care Staff (DCS) #5 and #6 were reviewed on 10/22/12 at 3:30 P.M. and indicated the following:</p> <p>The disciplinary report for DCS #5 dated 7/6/12 indicated DCS #5 was given a written warning for "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 8/2/12 indicated DCS #5's employment was terminated due to, "On 7/27/12 all staff and clients were checked and administered treatment for lice. You refused to allow the AWS nurse to check for lice at that time. On 7/31/12 the nurse requested that you be checked and you agreed. At that time it was determined that you still had lice and this led to exposure to clients after their first treatment was completed."</p> <p>The disciplinary report for DCS #6 dated 7/6/12 indicated DCS #6 was given a written warning for "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 10/8/12 indicated DCS #6's employment was</p>						

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	<p>terminated due to, "On 10/2/12 you were sent to [name of occupational health office] for retreatment of scabies. You had previously been sent to [name of occupational health office] on 5/25/12, 6/2/12, 9/20/12 and 9/28/12. Additionally you were sent to [name of occupational health office] on 7/31/12 for treatment of head lice and on 10/1/12 you reported to work with head lice again. Proper treatment and prevention of lice and scabies has been discussed with you by management and nursing staff on several occasions."</p> <p>2. A BDDS report dated 10/12/12 for 10/11/12 at 11:50 A.M. indicated "On October 11, 2012 at approximately 11:50 A.M. [client A] was attending his day program at AWA .... He began to choke at which time an AWA staff member (DPS #1) (Day Program Staff) gave back blows then performed the Heimlich as trained. As soon as the food/thickened liquid was expelled [client A] was acting normally and interacting with others. Staff contacted the nurse who immediately assessed [client A] and sent him to [Name of Hospital #2's] ER (emergency room) for further assessment per policy. [Client A] was given a chest x-ray which showed no signs of aspiration and was discharged. [Client A] will have a follow-up appointment with his primary care</p>			

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	<p>physician (PCP). [Client A's] dining plan indicates that his liquids should be thickened to nectar thick and the staff (DPS #2) had thickened the liquid too much to a pudding consistency. The AWS nurse has retrained the staff member on proper thickening of liquids. Staff will also visually check all meal/drink items to ensure proper consistency." The BDDS report indicated client A had his 02 stats, blood pressure and temperature monitored for the next seven days. The BDDS report also indicated the DPS who was feeding client A at the time of the incident (DPS #2) was retrained on appropriate liquid consistency.</p> <p>An interview with DPS #1 was conducted on 10/23/12 at 11:45 A.M. when asked about client A's choking incident DPS #1 stated, "I was just down there getting coffee for another consumer. I could tell [client A] was choking. I was just there, so I did it. I did back blows then started the Heimlich and back blows until it got out." DPS #1 indicated she had not been assigned to work with client A, but saw he needed help and started the choking protocol.</p> <p>An interview was conducted with the Day Program Assistant Director (DPAD) on 10/22/12 at 11:00 A.M. when asked about the choking incident for client A the</p>			
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	<p>DPAD stated, "When I spoke with [name of DPS #2], he used the tablespoon scoop instead of the teaspoon scoop by accident. It wasn't until he choked that the nurse noticed the thickness was wrong. [Name of DPS #1] did the back blows and Heimlich." The DPAD indicated DPS #2 was feeding client A the day he choked, and DPS #2 had not been the staff to initiate the emergency medical care.</p> <p>Confidential interview C stated, "I heard [client A] gurgle two times, and saw he wasn't breathing...His staff (DPS #2) was sitting right next to him. I don't think he noticed he was choking."</p> <p>The DPAD was again interviewed on 10/25/12 at 3:21 P.M.. When asked why DPS #2 did not initiate CPR for client A the DPAD stated, "When I questioned [name of DPS #2] he said he was assisting [client A]. [Name of DPS #1] asked if everything was ok, and he told her 'yes, doing good.' I am not sure if his attention was diverted, [name of DPS #1] walked by alerted [name of DPS #2] that [client A] was having some problems, and she jumped in to do CPR. [Name of DPS #2] was sitting between [client A] and the table, [name of DPS #1] was coming from the back and she was able to get to [client A's] back to do the back blows quicker than what [Name of DPS #2] would have</p>				

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	<p>been able to get around to him."</p> <p>The facility policy Group Home Abuse and Neglect dated 8/08 was reviewed on 10/23/12 at 12:12 P.M. and indicated the following: "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>On 10/25/12 at 3:49 P.M. the RD indicated the clients had been infested with scabies/lice by staff, and staff had neglected to follow policy. The RD indicated client A was given the wrong thickness of liquids with his meal and day program staff had neglected to follow his dining plan.</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-2(a)</p>				

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W0192	<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 to ensure day program staff was sufficiently trained on the correct texture of liquids, recognizing signs of choking and initiating emergency medical procedures for 1 of 4 sampled clients (client A) resulting in client A choking.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/12/12 for 10/11/12 at 11:50 A.M. indicated "On October 11, 2012 at approximately 11:50 A.M. [client A] was attending his day program at AWA.... He began to choke at which time an AWA staff member (DPS #1) (Day Program Staff) gave back blows then performed the Heimlich as trained. As soon as the food/thickened liquid was expelled [client A] was acting normally and interacting with others. Staff contacted the nurse who immediately</p>	W0192	All direct support staff have received additional training on appropriate texture modifications. The management staff are conducting spot checks at the day service to ensure that correct modification is being made to clients food. This is being documented on the dining skills checklist which is being monitored by the director for compliance.	11/25/2012			

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	<p>assessed [client A] and sent him to [Name of Hospital #2's] ER (emergency room) for further assessment per policy. [Client A] was given a chest x-ray which showed no signs of aspiration and was discharged. [Client A] will have a follow-up appointment with his primary care physician (PCP). [Client A's] dining plan indicates that his liquids should be thickened to nectar thick and the staff (DPS #2) had thickened the liquid too much to a pudding consistency. The AWS nurse has retrained the staff member on proper thickening of liquids. Staff will also visually check all meal/drink items to ensure proper consistency." The BDDS report indicated client A had his O2 stats, blood pressure and temperature monitored for the next seven days. The BDDS report also indicated the DPS who was feeding client A at the time of the incident (DPS #2) was retrained on appropriate liquid consistency.</p> <p>Employee Training Records were reviewed on 10/22/12 at 3:12 P.M.. The training record for DPS #2 indicated he was trained on American Red Cross Adult and Child CPR on 11/10/11, with an expiration date of 11/10/13. DPS #2 was trained on how to mix/measure thickening consistencies and pureed foods on 3/9/12 and retrained on 10/12/12, along with training on dysphagia precautions.</p>			

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	<p>An interview with DPS #1 was conducted on 10/23/12 at 11:45 A.M. when asked about client A's choking incident DPS #1 stated, "I was just down there getting coffee for another consumer. I could tell [client A] was choking. I was just there, so I did it. I did back blows then started the Heimlich and back blows until it got out." DPS #1 indicated she had not been assigned to work with client A, but saw he needed help and started the choking protocol.</p> <p>DPS #2 was unavailable for interview.</p> <p>An interview was conducted with the Day Program Assistant Director (DPAD) on 10/22/12 at 11:00 A.M. when asked about the choking incident for client A the DPAD stated, "When I spoke with [name of DPS #2], he used the tablespoon scoop instead of the teaspoon scoop by accident. It wasn't until he choked that the nurse noticed the thickness was wrong. [Name of DPS #1] did the back blows and Heimlich." The DPAD indicated DPS #2 was feeding client A the day he choked, and DPS #2 had not been the staff to initiate the emergency medical care. The DPAD indicated they didn't think DPS #2 had done anything wrong, but they had sent him back through CPR.</p>				

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	<p>Confidential interview C stated, "I heard [client A] gurgle two times, and saw he wasn't breathing...His staff (DPS #2) was sitting right next to him. I don't think he noticed he was choking."</p> <p>The DPAD was again interviewed on 10/25/12 at 3:21 P.M.. When asked why DPS #2 did not initiate CPR for client A, the DPAD stated, "When I questioned [name of DPS #2] he said he was assisting [client A]. [Name of DPS #1] asked if everything was ok, and he told her 'yes, doing good.' I am not sure if his attention was diverted, [name of DPS #1] walked by alerted [name of DPS #2] that [client A] was having some problems, and she jumped in to do CPR. [Name of DPS #2] was sitting between [client A] and the table, [name of DPS #1] was coming from the back and she was able to get to [client A's] back to do the back blows quicker than what [Name of DPS #2] would have been able to get around to him."</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-3(a)</p>				

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W0341	<p>483.460(c)(5)(ii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.</p> <p>Based on record review and interview, the facility nursing services failed to implement appropriate preventative and instructive health measures to prevent the ongoing infestation of scabies and/or lice for 4 of 4 sampled clients (clients A, B, C and D) and 2 additional clients (F and H).</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 9/13/12 for 9/12/12 at 6:00 P.M. indicated "On 9/12/12 he (client A) was taken to [Name of Hospital #1's] ER (emergency room) for evaluation of a red area on his left knee. He was determined to have MRSA (Methicillin resistant Staphylococcus aureus) and given a dose of IM (intra-muscular) antibiotics. He was also diagnosed with</p>	W0341	<p>AWS does have protocols in place for communicable diseases and infections. All nurses have received additional training on the scabies and lice protocols and the specific nurse reponsible has received counsiling for her failure to obtain a second opinion when the clients rashes were not releived by the prescribed treatment and her failure to appropriatly document all treatments in the health issues/nursing notes. Another staff nurse was assigned to this home prior to the survey and had gotten the treatments completed effectively and documentation complete. Should this type of incident recur, the director will monitor all scripts and client status weekly to ensure effective treatment. This monitoring has been added to the lice and scabies protocols to ensure proper monitoring and care of this type of situation and the need for a physicain to clear the staff and provide them with a "return to work" note.</p>	11/25/2012	

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	<p>scabies. He was given a steroid shot and prescribed Permethrin (pyrethrins for scabies treatment) 5% (five percent) cream and Artrax (sic) (antihistamine) to counter itching symptoms. [Client A] was discharged from the ER. He has been treated with the prescription cream. His clothing and bedding have all been laundered in hot water as directed. All furniture and floors have been vacuumed. The AWS scabies protocol was implemented."</p> <p>Client A's record was reviewed on 10/23/12 at 2:10 P.M.. Client A's nursing notes indicated the following: "9/13/12 Med's. (medication) started...skin rash treated per orders. Client tolerated well....9/9/12 Rash over body, manager made an appointment, encouraged to continue lotion by RX (prescription), 8/2/12...Rash remains continue to use lotion [name of doctor] does not feel it is scabies thinks it is a dermatitis from prior treatment. 7/28/12 Checked and treated for lice. Order from [name of doctor] received...6/27/12 New rach (sic) and itching all over will address c/ (with) [name of doctor] tomorrow at visit....5/22/12 Rash remains called [name of doctor] new lotion ordered....5/16/12 Rash remains but continues to dry....5/9/12 Rash remains...5/4/12 Skin rash remains...5/3/12 ...skin rash." The</p>			

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	<p>BDDS report dated 9/13/12 indicated his rash was diagnosed as scabies and treated with Permethrin cream. Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS (hour of sleep) tonight then again in 7 (seven) days."</p> <p>Client B's record was reviewed on 10/23/12 at 2:28 P.M.. Client B's nursing notes indicated the following: "9/1/12 [client B] has a rash itching all over. Had staff make an appointment /c [name of doctor]...7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/30/12 indicated "Treatment for lice as instructed by doctor okay." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." A doctor's appointment form dated 9/13/12 indicated client B was diagnosed with scabies and treated with Permethrin Cream.</p> <p>Client C's record was reviewed on 10/23/12 at 2:51 P.M.. Client C's nursing notes indicated the following: " 7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' (over the counter) medication" Physician's orders dated</p>						

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	<p>5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>Client D's record was reviewed on 10/23/12 at 3:12 P.M.. Client D's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified....5/23/12 Rash to bilateral (upper) ext. (extremities). Called [name of dermatologist] for lotion...will use as directed." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication." Client D's MAR (medication administration record) dated for May 2012 indicated she was treated with Permethrin cream on 5/24/12 and 5/31/12.</p> <p>Client F's record was reviewed on 10/23/12 at 3:25 P.M.. Client F's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Order obtained per [name of doctor] guardian notified..." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication."</p> <p>Client H's record was reviewed on 10/23/12 at 3:43 P.M.. Client H's nursing notes indicated the following: "9/3/12...'itching skin' DX (diagnosis) Scabies will tx (treat) per orders. Steroid shot given per [name of doctor's nurse]"</p>						

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	<p>and anti itch med's. (medication)...7/28/12 Checked and treated for lice. Order received from [name of doctor] guardian notified....7/18/12 ...Client continues to scratch at head and arms has scratch marks. No rash seen. Encouraged staff to utilize his lotions that were ordered...5/22/12 Rash remains...called in for lotion....5/4/12 Skin remains with rash...." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>The RD was interviewed on 10/22/12 at 3:15 P.M.. "The RD stated, "They were brought into the house by staff. We have terminated two staff."</p> <p>Employee Disciplinary Reports for Direct Care Staff (DCS) #5 and #6 were reviewed on 10/22/12 at 3:30 P.M. and indicated the following:</p> <p>The disciplinary report for DCS #5 dated 7/6/12 indicated DCS #5 was given a written warning, "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 8/2/12 indicated DCS #5's employment was terminated due to, "On 7/27/12 all staff and clients were checked and administered treatment for lice. You</p>				

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	<p>refused to allow the AWS nurse to check for lice at that time. On 7/31/12 the nurse requested that you be checked and you agreed. At that time it was determined that you still had lice and this lead to exposure to clients after their first treatment was completed."</p> <p>The disciplinary report for DCS #6 dated 7/6/12 indicated DCS #6 was given a written warning, "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 10/8/12 indicated DCS #6's employment was terminated due to, "On 10/2/12 you were sent to [name of occupational health office] for retreatment of scabies. You had previously been sent to [name of occupational health office] on 5/25/12, 6/2/12, 9/20/12 and 9/28/12. Additionally you were sent to [name of occupational health office] on 7/31/12 for treatment of head lice and on 10/1/12 you reported to work with head lice again. Proper treatment and prevention of lice and scabies has been discussed with you by management and nursing staff on several occasions."</p> <p>An email dated 9/26/12 at 4:41 P.M. was reviewed on 10/22/12 at 3:48 P.M. indicating AWS was requesting all staff who worked at the group home to pick up</p>			

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	<p>free prescriptions for themselves and any family members in their home for treatment (of scabies).</p> <p>The facility's Scabies Infestation Protocol, undated, was reviewed on 10/23/12 at 9:12 A.M.. The protocol indicated "...If a rash that is suspected to be scabies is found on an individual's skin the individual should be seen by their physician...they may return to work 2 (two) days after the treatment has been applied...Treatment requires a physician's order..follow directions by physician or on the package label...apply medication to a clean body from neck down to toes...shower after leaving the medication on for the recommended time...dress in clean clothes...a second treatment may be necessary, only with a physician's order...itching may continue for 2-3 (two-three) weeks...physician may prescribe medication to relieve itching...if itching continues more than 2-4 (two to four) weeks or if new burrows or rash continue to appear, seek the advice of a physician; retreatment may be necessary with the same or different scabicide...all household members and others with close prolonged contact should be checked...all clothing, bedding, and towels worn or used by the infested person in the 3 (three) day period before treatment is started are to be machine washed and</p>				

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	<p>dried using hot water and hot air cycles...vacuuming furniture and floors can remove possible infestation...if a staff member thinks they may have have scabies...they should notify their supervisor, employee will be instructed to seek medical attention...."</p> <p>An interview was conducted with a facility LPN on 10/25/12 at 3:58 P.M.. The LPN stated, "Every time rash is written in the nursing notes we (the RN or one of the LPN's) completed a hands on assessment, we checked everyone even staff."</p> <p>An interview was conducted with the Residential Director (RD) on 10/25/12 at 3:55 P.M.. The RD stated, "We followed the scabies protocol, we treated everyone who had any symptoms, even if the doctor did not diagnose them with scabies. We called the doctor and informed him we had a confirmed positive scabies in the house, which was a staff, and got the doctor recommendations to be proactive so we could treat everyone." The RD did not indicate how the staff were being checked/proven clear of infestation to be able to have direct contact with the clients in the group home.</p> <p>This Federal tag relates to complaint #IN00117587.</p>						

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	9-3-6(a)			

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W0382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on record review and interview, the facility failed to maintain a system to keep medications locked during day program transport/community outings for 1 of 4 sampled clients (client B) who gained access to a medication card during a facility owned/operated day program outing.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/5/12 for an incident on 10/4/12 at 3:00 P.M. indicated "On 10/4/12 [client B] gained access to a medication card (Seroquel 400 milligram tablets) (anti-psychotic) during a community activity with her (sic) day services staff and we could not say with certainty that no medication had been taken by [client B]; therefore, he was taken to [Name of Hospital #1's] ER (emergency room) for evaluation/ (sic) There were no medical indications that</p>	W0382	<p>All day service staff have received additional training on the appropriate storage of medication including when they are out of the day service facility and need to transport medications. Lockes bags are being used and management will periodically spot checks to ensure appropriate storage of medications is being maintained. These checks will be documented on a Medication Administration tracking form and the directorswill review the checks for compliance.</p>	11/25/2012			

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	<p>[client B] had ingested any medication and he was released from the hospital. There is no medical follow-up required. The medication was later then discovered and it was confirmed that no medication had been taken by [client B]."</p> <p>The facility policy "Storage of Medication" dated 11/1/2006 was reviewed on 10/23/12 at 12:20 P.M.. The policy indicated "To ensure that all medications are stored under proper conditions of sanitation, temperature, light, humidity and security...1. All medications which an employee administers to a client are to be stored in a designated location....The medication may be stored in a locked cabinet or medication box."</p> <p>An interview was conducted with the Day Program Assistant Director (DPAD) on 10/25/12 at 3:21 P.M.. When asked how client B was able to gain access to a medication card, the DPAD stated, "A staff had the bubble pack of medication between her and the car seat. We always locked up controlled medications on outings, but not others always were locked, now they all are locked each time. There had been eight pills in the card in the morning. One pill was administered at noon. Two pills were still in the card, but five were missing. A peer in the vehicle</p>						

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	<p>was the one who actually got the card, but we were concerned she might have given some to [client B]. We took both clients to the hospital as a precaution, but found the five pills later in the peer's coat pockets." The DPAD stated, "We now lock up all medications during outings."</p> <p>An interview was conducted with the Residential Director (RD) on 10/22/12 at 3:15 P.M.. When asked about what happened with client B gaining access to a medication card, the RD stated, "The medication was not secured during transport during a day services outing. All the staff have been retrained on medication security."</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-6(a)</p>				

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W0456	<p>483.470(l)(2) INFECTION CONTROL</p> <p>The facility must implement successful corrective action in affected problem areas. Based on record review and interview, the facility failed to implement successful corrective actions to prevent the ongoing infestation of scabies and/or lice for 4 of 4 sampled clients (clients A, B, C and D) and 2 additional clients (F and H).</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 9/13/12 for 9/12/12 at 6:00 P.M. indicated "On 9/12/12 he (client A) was taken to [Name of Hospital #1's] ER (emergency room) for evaluation of a red area on his left knee. He was determined to have MRSA (Methicillin resistant Staphylococcus aureus) and given a dose of IM (intra-muscular) antibiotics. He was also diagnosed with scabies. He was given a steroid shot and prescribed Permethrin (pyrethrins for scabies treatment) 5% (five percent) cream and Artrax (sic) (antihistamine) to counter itching symptoms. [Client A] was discharged from the ER. He has been</p>	W0456	AWS does have protocols in place for communicable diseases and infections. All nurses have received additional training on the scabies and lice protocols and the specific nurse responsible has received counseling for her failure to obtain a second opinion when the clients rashes were not relieved by the prescribed treatment and her failure to appropriately document all treatments in the health issues/nursing notes. Another staff nurse was assigned to this home prior to the survey and had gotten the treatments completed effectively and documentation complete. Should this type of incident recur, the director will monitor all scripts and client status weekly to ensure effective treatment. This monitoring has been added to the lice and scabies protocols to ensure proper monitoring and care of this type of situation and the need for a physician to clear the staff and provide them with a "return to work" note.	11/25/2012			

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	<p>treated with the prescription cream. His clothing and bedding have all been laundered in hot water as directed. All furniture and floors have been vacuumed. The AWS scabies protocol was implemented."</p> <p>Client A's record was reviewed on 10/23/12 at 2:10 P.M.. Client A's nursing notes indicated the following: "9/13/12 Med's. (medication) started...skin rash treated per orders. Client tolerated well....9/9/12 Rash over body, manager made an appointment, encouraged to continue lotion by RX (prescription), 8/2/12...Rash remains continue to use lotion [name of doctor] does not feel it is scabies thinks it is a dermatitis from prior treatment. 7/28/12 Checked and treated for lice. Order from [name of doctor] received...6/27/12 New rash (sic) and itching all over will address c/ (with) [name of doctor] tomorrow at visit....5/22/12 Rash remains called [name of doctor] new lotion ordered....5/16/12 Rash remains but continues to dry....5/9/12 Rash remains...5/4/12 Skin rash remains...5/3/12 ...skin rash." The BDDS report dated 9/13/12 indicated his rash was diagnosed as scabies and treated with Permethrin cream. Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS (hour of sleep) tonight</p>			

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	<p>then again in 7 (seven) days."</p> <p>Client B's record was reviewed on 10/23/12 at 2:28 P.M.. Client B's nursing notes indicated the following: "9/1/12 [client B] has a rash itching all over. Had staff make an appointment /c [name of doctor]...7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/30/12 indicated "Treatment for lice as instructed by doctor okay." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days." A doctor's appointment form dated 9/13/12 indicated client B was diagnosed with scabies and treated with Permethrin Cream.</p> <p>Client C's record was reviewed on 10/23/12 at 2:51 P.M.. Client C's nursing notes indicated the following: " 7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified...." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' (over the counter) medication" Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>Client D's record was reviewed on 10/23/12 at 3:12 P.M.. Client D's nursing</p>						

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	<p>notes indicated the following: "7/28/12 Checked and treated for lice. Orders from doctor. Guardian notified....5/23/12 Rash to bilateral (upper) ext. (extremities). Called [name of dermatologist] for lotion...will use as directed." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication." Client D's MAR (medication administration record) dated for May 2012 indicated she was treated with Permethrin Cream on 5/24/12 and 5/31/12.</p> <p>Client F's record was reviewed on 10/23/12 at 3:25 P.M.. Client F's nursing notes indicated the following: "7/28/12 Checked and treated for lice. Order obtained per [name of doctor] guardian notified...." Physician's orders dated 7/28/12 indicated "May treat for lice 'OTC' medication."</p> <p>Client H's record was reviewed on 10/23/12 at 3:43 P.M.. Client H's nursing notes indicated the following: "9/3/12...'itching skin' DX (diagnosis) Scabies will tx (treat) per orders. Steroid shot given per [name of doctor's nurse] and anti itch med's. (medication)...7/28/12 Checked and treated for lice. Order received from [name of doctor] guardian notified....7/18/12 ...Client continues to scratch at head and arms has scratch marks. No rash seen. Encouraged staff to</p>			

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	<p>utilize his lotions that were ordered...5/22/12 Rash remains...called in for lotion...5/4/12 Skin remains with rash...." Physician's orders dated 5/24/12 indicated "Permethrin cream 5% apply topically from neck down body at HS tonight then again in 7 days."</p> <p>The facility's Scabies Infestation Protocol, undated, was reviewed on 10/23/12 at 9:12 A.M.. The protocol indicated "...If a rash that is suspected to be scabies is found on an individual's skin the individual should be seen by their physician...they may return to work 2 (two) days after the treatment has been applied...Treatment requires a physician's order..follow directions by physician or on the package label...apply medication to a clean body from neck down to toes...shower after leaving the medication on for the recommended time...dress in clean clothes...a second treatment may be necessary, only with a physician's order...itching may continue for 2-3 (two-three) weeks...physician may prescribe medication to relieve itching...if itching continues more than 2-4 (two to four) weeks or if new burrows or rash continue to appear, seek the advice of a physician; retreatment may be necessary with the same or different scabicide...all household members and others with close prolonged contact should be checked...all</p>			

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	<p>clothing, bedding, and towels worn or used by the infested person in the 3 (three) day period before treatment is started are to be machine washed and dried using hot water and hot air cycles...vacuuming furniture and floors can remove possible infestation...if a staff member thinks they may have have scabies...they should notify their supervisor, employee will be instructed to seek medical attention...."</p> <p>An interview was conducted with a facility LPN on 10/25/12 at 3:58 P.M.. The LPN stated, "Every time rash is written in the nursing notes we (the RN or one of the LPN's) do a hands on assessment, and we checked everyone, even staff."</p> <p>An interview was conducted with the Residential Director (RD) on 10/25/12 at 3:55 P.M.. The RD stated, "We followed the scabies protocol, we treated everyone who had any symptoms, even if the doctor did not diagnose them with scabies. We called the doctor and informed him we had a confirmed positive scabies in the house, which was a staff, and got the doctor recommendations to be proactive so we could treat everyone." The RD stated, "Not every time rash is written in the nursing notes was it scabies or head lice. Several of the clients have other skin</p>						

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	<p>conditions." The RD indicated the nursing notes did not always have corresponding diagnoses/treatment listed for each time rash was listed in the notes, but usually there was a corresponding physician's order, medical form, or the MAR to refer to.</p> <p>Confidential interview A stated, "I thought there would have been more details written in the nursing notes as far as diagnosis and treatments."</p> <p>Confidential interview B stated, "It would normally all be written in the nursing notes."</p> <p>The RD was interviewed on 10/22/12 at 3:15 P.M.. "The RD stated, "They were brought into the house by staff. We have terminated two staff."</p> <p>Employee Disciplinary Reports for Direct Care Staff (DCS) #5 and #6 were reviewed on 10/22/12 at 3:30 P.M. and indicated the following:</p> <p>The disciplinary report for DCS #5 dated 7/6/12 indicated DCS #5 was given a written warning, "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 8/2/12 indicated DCS #5's</p>				

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	<p>employment was terminated due to, "On 7/27/12 all staff and clients were checked and administered treatment for lice. You refused to allow the AWS nurse to check for lice at that time. On 7/31/12 the nurse requested that you be checked and you agreed. At that time it was determined that you still had lice and this led to exposure to clients after their first treatment was completed."</p> <p>The disciplinary report for DCS #6 dated 7/6/12 indicated DCS #6 was given a written warning, "failed to be consistent with keeping the group home clean and to use universal precautions daily and every time the staff worked in the group home." A report dated 10/8/12 indicated DCS #6's employment was terminated due to, "On 10/2/12 you were sent to [name of occupational health office] for retreatment of scabies. You had previously been sent to [name of occupational health office] on 5/25/12, 6/2/12, 9/20/12 and 9/28/12. Additionally you were sent to [name of occupational health office] on 7/31/12 for treatment of head lice and on 10/1/12 you reported to work with head lice again. Proper treatment and prevention of lice and scabies has been discussed with you by management and nursing staff on several occasions."</p> <p>An email dated 9/26/12 at 4:41 P.M. was</p>						

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	<p>reviewed on 10/22/12 at 3:48 P.M. indicating AWS was requesting all staff who worked at the group home to pick up free prescriptions for themselves and any family members in their home for treatment (of scabies).</p> <p>This Federal tag relates to complaint #IN00117587.</p> <p>9-3-7(a)</p>				

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W0474	<p>483.480(b)(2)(iii) MEAL SERVICES</p> <p>Food must be served in a form consistent with the developmental level of the client. Based on record review and interview, the facility failed to ensure day program staff (DPS #2) provided the appropriate thickness/texture of liquids at lunch while he was feeding 1 of 4 sampled clients (client A) resulting in client A choking.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/22/12 at 2:35 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 5/1/12 through 10/22/12. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/12/12 for 10/11/12 at 11:50 A.M. indicated "On October 11, 2012 at approximately 11:50 A.M. [client A] was attending his day program at AWA.... He began to choke at which time an AWA staff member (DPS #1) (Day Program Staff) gave back blows then performed the Heimlich as trained. As soon as the food/thickened liquid was expelled [client A] was acting normally and interacting with others. Staff contacted the nurse who immediately assessed [client A] and sent him to [Name of Hospital #2's] ER (emergency room) for further assessment per policy. [Client</p>	W0474	All direct support staff have received additional training on appropriate texture modifications. The management staff are conducting spot checks at the day service to ensure that correct modifacaton is being made to clients food. This is being documented on the dining skills checklist which is being monitored by the director for complaince.	11/25/2012			

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	<p>A] was given a chest x-ray which showed no signs of aspiration and was discharged. [Client A] will have a follow-up appointment with his primary care physician (PCP). [Client A's] dining plan indicates that his liquids should be thickened to nectar thick and the staff (DPS #2) had thickened the liquid too much to a pudding consistency. The AWS nurse has retrained the staff member on proper thickening of liquids. Staff will also visually check all meal/drink items to ensure proper consistency." The BDDS report indicated client A had his 02 stats, blood pressure and temperature monitored for the next seven days. The BDDS report also indicated the DPS who was feeding client A at the time of the incident (DPS #2) was retrained on appropriate liquid consistency.</p> <p>Observations were conducted at the day program on 10/23/12 from 11:02 A.M. until 12:09 P.M.. Client A was eating his lunch. DPS #3 was feeding client A a pureed meal with nectar thick water. At 11:35 A.M. on 10/23/12 DPS #3 was asked what client A's diet order was. DPS #3 stated, "Pureed foods, and nectar thick liquids." In the kitchen area where the lunches were prepared there was a form posted describing how much thickening agent should be used per ounce of liquid.</p>			

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	<p>Client A's record was reviewed on 10/24/12 at 3:04 P.M.. Client A's record indicated he had a dining plan dated 10/11/12. The dining plan indicated client A was to have a "pureed diet with nectar liquids / all foods in blender."</p> <p>An interview with DPS #1 was conducted on 10/23/12 at 11:45 A.M. when asked about client A's choking incident DPS #1 stated, "I was just down there getting coffee for another consumer. I could tell [client A] was choking. I was just there, so I did it. I did back blows then started the Heimlich and back blows until it got out." DPS #1 indicated she had not been assigned to work with client A, but saw he needed help and started the choking protocol.</p> <p>An interview was conducted with the Day Program Assistant Director (DPAD) on 10/22/12 at 11:00 A.M. when asked about the choking incident for client A the DPAD stated, "When I spoke with [name of DPS #2], he used the tablespoon scoop instead of the teaspoon scoop by accident. It wasn't until he choked that the nurse noticed the thickness was wrong. [Name of DPS #1] did the back blows and Heimlich."</p> <p>This Federal tag relates to complaint #IN00117587.</p>				

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