

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G711	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/29/2012
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 568 HILDEBRAND ST SOUTH BEND, IN 46614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 27, 28 and 29, 2012.</p> <p>Facility Number: 003861 Provider Number: 15G711 AIMS Number: 200460460</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 9/5/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 2 clients (clients #2 and #3) with a gastrointestinal tube (G-tube) to ensure their medical needs were met when administering medications through the tube.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 08/27/12 from 3:34 PM until 6:30 PM. The observation included a medication pass which started at 5:25 PM. Client #3 was wheeled into the medication room at 5:14 PM. Staff #1 measured 240 cc (cubic centimeters) of water into a plastic container and used 30 cc of the water to flush the G-tube before the medication was given. Staff #1 used 15 cc of the water to mix with the medicine she opened from a capsule (Potassium Cl (chloride) ER (extended release) 10 mEq (milliequivalents) (hypokalemia) and placed in a medication cup. Staff #1 administered the medication through the G-tube and then poured the remaining amount of the water into the syringe connected to the tube. The August 2012 MAR contained the</p>	W0331	<p>The water flush order for Ct #3 has been modified to ensure an adequate amount of water is administered with the medication. All staff have received training on the water flush orders for Ct's #2 and #3 as well as the procedure for administering medications through a gastrointestinal tube. The manager, QMRP, and the nurse are monitoring staff to ensure their training has been effective. These observations will be documented on a medication observation checklist and reviewed by the director to ensure compliance.</p>	09/28/2012			

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	<p>following information: Potassium Cl ER 10 mEq capsule; open 1 capsule and pour into 15 cc water and give via G-tube 4 times a day - follow with 240 cc water. Staff #1 failed to administer 240 cc of water after the Potassium.</p> <p>Client #3's records were reviewed on 08/28/12 at 12:30 PM. Client #3's record review included review of the following dated documents:</p> <p>08/2012: Physician Orders contained the following order: Potassium Cl ER 10 mEq capsule; open 1 capsule and pour into 15 cc water and give via G-tube 4 times a day - follow with 240 cc water.</p> <p>On 08/29/12 at 12:30 PM, an interview was conducted with the Residential Director/Registered Nurse (RD/RN). The RD/RN indicated staff #1 should have used 240 cc of water after giving the potassium.</p> <p>2. Observations were conducted at the group home on 08/27/12 from 3:34 PM until 6:30 PM. The observation included a medication pass which started at 5:25 PM. Client #2 was wheeled into the medication room at 5:45 PM. Staff #1 measured 200 cc of water into a plastic container. Staff #1 crushed client #2's first tablet and mixed it with 30 cc of water</p>						

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	<p>from the 200 cc container and administered it down the G-tube at 5:48 PM. Staff #1 failed to administer 30 cc of water down the tube before administering client #2's first medication.</p> <p>The Gastrointestinal Feeding, Medication Administration and Site Care policy dated 05/01/08 was reviewed on 8/28/12 at 1:00 PM. The policy indicated, "...Check for G-Tube placement...Check for residual...Flush tube with 30 cc water...".</p> <p>On 08/29/12 at 12:30 PM, an interview was conducted with the Residential Director/Registered Nurse (RD/RN). The RD/RN indicated staff #1 should have flushed the G-tube with 30 cc of water prior to administering any medication.</p> <p>9-3-6(a)</p>						