

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 4225 OLD MILL RD FORT WAYNE, IN 46807
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: April 8, 9, 10 and 11, 2014.</p> <p>Facility number: 001197 Provider number: 15G659 AIM number: 100249000</p> <p>Surveyor: Kathy Wanner, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/21/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to assure all medications were administered in accordance with the physician's orders for 2 of 4 additional clients (clients #5 and #7).</p> <p>Findings include:</p> <p>Facility records were reviewed on 4/8/14 at 12:42 P.M., including the Bureau of Developmental Disabilities Services (BDDS) reports.</p> <p>A BDDS report dated 9/28/13 for an incident on 9/27/13 at 8:00 A.M. indicated client #5 was administered 20mg (milligrams) of Abilify</p>	W000368	<p>When the error was discovered on 8/21/13 the staff was immediately retrained and counseled on appropriate medication administration policies/procedures stressing that when you add a new medication that you discontinue the old dosage from the MAR (medication administration record). The on call will be contacted to ensure that the medication is appropriately added and/or discontinued.</p> <p>When the medication error was discovered on 9/27/13 the pharmacy was contacted and a new card was issued. The entire</p>	05/11/2014

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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	<p>(anti psychotic) on 9/26/13 and 9/27/13 instead of the 2mg of Abilify ordered by his physician. The BDDS report indicated the pharmacy had delivered a medication card of Abilify 20mg tablets in error. Client #5 was assessed by the LPN and his physician was notified. No new orders were received. Client #5 was monitored and vitals were taken, which remained within normal ranges. Client #5 had no ill effects from the medication errors.</p> <p>A BDDS report dated 8/21/13 for an incident on 8/20/13 at 6:30 A.M. indicated client #7's psychiatrist ordered a change in dose for client #7's citalopram (anti-depressant) from 20mg to 40mg. The staff administering the medication did not discontinue the old dosage from the MAR (medication administration record) and gave both a 20mg citalopram tablet and a 40mg citalopram tablet for a total of 60mg. The LPN assessed client #7. Client #7's vitals remained normal and client #7 had no ill effects. Client #7's psychiatrist was notified. Staff were counseled and retrained.</p> <p>An interview was conducted with the LPN on 4/10/14 at 12:20 P.M. The LPN stated, "The staff should have caught the errors during their checks. The medication errors were significant errors." The LPN indicated routine medications were checked each month by a facility nurse, but if a medication changes or a dose changes, the new medication is delivered to the home and the staff transcribe the new order onto the MAR (medication administration record). The LPN indicated since the two significant medication errors occurred the staff are now to call the LPN when pharmacy delivers a medication and check to ensure the medication delivered is</p>		<p>house staff were instructed to look at all new medications and ensure that the dosage on the pack matches the dosage on the physician's order. They were also instructed to contact the on call. Management staff will ensure that the medication delivered was indeed the medication ordered by the physician. Management staff will also ensure that all new medications are appropriately written and medications discontinued when appropriate. Managers and Nurses continue to complete weekly checks on an ongoing basis of medication administration and this is documented on the medication administration tracking form. This includes checking the medication cabinet, MAR, and completing medication passing observations. This form is turned into the director monthly and monitored for compliance and to monitor that the training was effective.</p>				

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W000369	<p>what the physician ordered and to ensure staff understand the changes.</p> <p>9-3-6(a) 483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed to assure all medications administered to 1 of 4 additional clients (client #6) were administered without error.</p> <p>Findings include:</p> <p>Observations of the 6:30 A.M. medication pass for client #6 were conducted on 4/10/14 at 5:52 A.M. Client #6 in addition to his other morning medications was administered Calcium (supplement) 600mg (milligrams) with vitamin D 400 IU, Abilify (anti-psychotic) 2mg, and Divalproex Sodium (anti-convulsant) 250mg.</p> <p>Client #6's MAR (medication administration record) dated for 4/2014 was reviewed on 4/10/14 at 6:00 A.M. and indicated "Calcium 600mg with vitamin D 400 IU give 1 tablet orally two times a day with food to reduce the rate of bone loss, Abilify 2mg give 1 tablet orally every morning after breakfast for mood disorder, and Divalproex Sodium 250mg give 1 tablet orally three times a day after meals for seizures."</p> <p>On 4/10/14 Client #6 began to eat his morning meal at 6:40 A.M. This was 48</p>	W000369	<p>On 4-25-14 all staff have received additional training on the medication administration policies/procedures. This includes reading each and every instruction for the medication on MAR's have been reviewed to ensure all special instructions from the physician are implemented as prescribed. The manager and nurse will also review all new MAR's to ensure that all special instructions are implemented as prescribed by the physician. Managers and Nurses continue to complete weekly checks on an ongoing basis of medication administration and this is documented on the medication administration tracking form. This includes checking the medication cabinet, MAR, and completing medication passing observations. This form is turned into the director monthly and monitored for compliance and to monitor that the training was effective.</p>	05/11/2014

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	<p>minutes after receiving his medications.</p> <p>Direct Care Staff (DCS) #1 was interviewed on 4/10/14 at 6:04 A.M. DCS #1 stated, "Yes, his Calcium is to be given with food and he is about to eat breakfast. Yes, Abilify and Divalproex do say after meals, so we need to change the times we give those to him (client #6). I will let the residential manager know."</p> <p>The LPN was interviewed on 4/10/14 at 12:20 P.M. The LPN indicated client #6 had received his meal soon enough after he ate regarding the Calcium being administered with food. The LPN stated, "The Divalproex, the doctor continues to write the order differently, sometimes after meals sometimes it doesn't specify. The Abilify order just slipped through. They need to be given after meals."</p> <p>9-3-6(a)</p>			