

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G729		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 4331 MELBOURNE RD INDIANAPOLIS, IN 46228			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: October 9, 10 and 11, 2013.</p> <p>Facility Number: 011220 Provider Number: 15G729 AIMS Number: 200839230</p> <p>Surveyor: Claudia Ramirez, RN</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 23, 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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W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #1) who were on medications related to behaviors, by not ensuring the client's Behavior Support Plan (BSP) included the medication or a titration plan for the medications in the plan.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 10/10/13 at 10:00 AM. Client #1's BSP dated 03/03/13 indicated client #1's behaviors included physical aggression, extreme irritability, temper outbursts, inappropriate sexual behavior, shredding and incontinence. The BSP contained an addendum #2 dated 03/03/13 named, "Medication Reduction Plan." The Medication Reduction Plan indicated he was on the following medications for the behaviors: Prozac for depression, Clonazepam for anxiety/agitation and Seroquel for agitation/aggression. The BSP's medication reduction plan indicated client #1 needed to reduce the behaviors, "to no more than 0 incidents per month for 6 consecutive months...Then the IDT (Inter-Disciplinary Team) will make a recommendation to his psychiatrist to reduce psychotropic medication...." The BSP did not contain an attainable titration plan.</p> <p>On 10/11/13 at 10:50 AM an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated</p>	W000312	An addendum was made on 10-16-13 to client #1's BSP to revise the titration plan to make it attainable. A copy of the revised BSP is included in this Plan of Correction, with the changes outlined on pages 12 through 15. All BSPs will be reviewed at least quarterly by the IDT to determine if the titration plan is appropriate.	11/10/2013			

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	client #1's BSP should contain a titration plan that was attainable.  9-3-5(a)				

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W000331	<p><b>483.460(c) NURSING SERVICES</b> 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 1 of 2 sampled clients (client #1), to ensure clients received nursing services according to their medical needs: by failing to ensure client #1's Fall Risk Protocol included client #1's use of the seat belt in the wheelchair and by failing to monitor and document the skin integrity of client #1.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/09/13 from 3:45 PM until 6:45 PM and staff #1 and #2 were on duty. During the entire observation time, client #1 was seated in his wheelchair and did not have the seat belt fastened. On 10/09/13 at 6:45 PM staff #1 was asked if client #1's seat belt was to be fastened. She stated, "yes." Staff #1 checked client #1's seat belt, it was not fastened and she fastened it.</p> <p>Client #1's records were reviewed on 10/10/13 at 10:00 AM. There was a BDDS (Bureau of Developmental Disabilities Services), report for client #1 dated 07/30/13. The report indicated client #1 fell out of his wheelchair and onto the floor. Client #1's Fall Risk Protocol date initiated 01/10/13 indicated client #1 used a wheelchair for mobility. The protocol did not mention the seat belt on the wheelchair or that the seat belt should be fastened for client #1's safety. Client #1's Case Analysis dated 09/22/12 prior to his admission indicated, "[Client #1] cannot walk without assistance and is also at risk for falling from his wheelchair. He often falls when reaching down for something that the (sic) dropped and has to</p>	W000331	Client #1's Risk Plan will be updated to include the use of his wheelchair seat belt. Client #1's Skin Risk Protocol will be updated to include monitoring for signs of breakdown. Staff will document daily that the result of this monitoring. All staff in the home will received training regarding the updates to Risk Plans. All risk plans will be reviewed quarterly by the IDT to determine if they are appropriate and current. The AWS Nurse will monitor to ensure and verify that each client Risk Plan is appropriate and report to the IDT during client quarterly and annual meetings.	11/10/2013			

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	<p>have a seat belt for safety."</p> <p>BDDS reports dated 03/30/13 and 06/10/13 indicated client #1 had been treated at the hospital with IV (intravenous) antibiotic for skin "boils." A follow-up report dated 06/17/13 indicated the drainage of the lesions was positive for MRSA. (Methicillin-resistant Staphylococcus aureus). Client #1's physical dated 02/11/13 indicated client #1's history included MRSA infections. Client #1's Skin Risk Protocol dated 01/10/13 indicated client #1's skin was to be monitored daily for redness and for signs of skin breakdown. The protocol did not include any documentation of the skin monitoring.</p> <p>On 10/11/13 at 10:50 AM an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #1's wheelchair seat belt should be fastened at all times and staff should monitor that it is fastened. She indicated client #1 likes to unfasten his seat belt and the use of his seat belt should be in his risk plan. The QIDP also indicated client #1 has a history of MRSA and has been treated for infections which required IV therapy and hospitalization. She indicated staff should monitor his skin daily and document the results of the monitoring. The QIDP indicated there was no documentation of the skin monitoring currently.</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION 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 for 1 of 2 sampled clients (client #1), and 1 additional client (client #4), who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 10/09/13 at 11:51 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports was completed and included the following medication errors:</p> <p>03/01/13: "[Client #4] takes Baclofen 10 mg (milligram) tablets...for muscle relaxant...also takes Omeprazole...for GERD (Gastroesophageal reflux disease)...found that [client #4's] Baclofen and Omeprazole were not popped out of the package for first shift...these medications were signed for but were not given...."</p> <p>04/04/13: "...On 04/04/13 [client #1] was given Depakote (seizures) 250 mg...This medication was discontinued...."</p> <p>09/09/13: "...[Client #1] received another resident's Valium (anxiety) 5 mg tablet...."</p> <p>On 10/11/13 at 10:50 AM an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.</p>	W000368	All staff at this group home will receive retraining regarding medication administration procedures from the AWS Nurse. All staff at this group home will demonstrate acceptable competency by completing a skills/step form. The AWS Nurse will conduct med pass observations weekly to ensure continued compliance.	11/10/2013			

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W000369	<p><b>483.460(k)(2) DRUG ADMINISTRATION</b></p> <p>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 for 5 of 17 medication doses administered at the PM medication administration, the facility failed to follow physician orders for administering medication to 1 additional client (client #3).</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 10/09/13 from 3:45 PM until 6:45 PM and staff #1 and #2 were on duty. At 5:00 PM client #3 was assisted into the medication area. Staff #1 prepared client #3's oral medications and at 5:04 PM, client #3 took her medications. Client #3's medications included Topamax (seizures), Keppra (seizures), Depakote (seizures), Calcium Acetate (renal insufficiency) and Sodium Bicarb (bicarbonate/metabolic acidosis).</p> <p>Client #3's October 2013 MAR (Medication Administration Record) was reviewed on 10/09/13 at 5:05 PM. The MAR indicated client #1 had the following medications which were ordered to be given at 6:30 PM: Topamax (seizures), Keppra (seizures), Depakote (seizures), Calcium Acetate (renal insufficiency) and Sodium Bicarb (metabolic acidosis).</p> <p>An interview was conducted on 10/10/13 at 8:20 AM with the RN (Registered Nurse). The RN indicated the medications had scheduled times to be given, but the staff could give them an hour before or an hour after the scheduled time. She indicated staff #1 should not have given client #3</p>	W000369	Staff #1 will complete retraining regarding appropriate med pass procedures from the AWS Nurse. A med pass observation will be completed by the AWS Nurse with Staff #1. All staff at this group home will receive retraining regarding medication administration procedures from the AWS Nurse. All staff at this group home will demonstrate acceptable competency by completing a skills/step form. The AWS Nurse will conduct weekly med pass observations to ensure continued compliance.	11/10/2013

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	<p>her medications at 5:04 PM and the earliest she could have given them was 5:30 PM. She indicated 5:04 PM was outside of the accepted time frames. She indicated these were medication errors and the times needed to be followed especially with seizure medications and other medications where timing was important. She indicated staff #1 failed to administer client #1's medication as ordered.</p> <p>9-3-6(a)</p>				