

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 04/17/2014
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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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(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
W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of survey: April 15, 16 and 17, 2014. Facility number: 012625 Provider number: 15G803 AIM number: 201023250 Surveyor: Susan Reichert, QIDP	W000000		
W000192	The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 4/22/14 by Ruth Shackelford, QIDP. 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. Based on record review and interview, the facility failed for 1 of 2 deceased clients (client #9) to ensure staff correctly implemented training protocol for CPR (cardiopulmonary resuscitation) techniques during cardiac distress. Findings include: The facility's reportable incidents to the Bureau of Developmental Disability Services (BDDS) were reviewed on 4/15/14 at 3:55 PM. A BDDS report dated 3/15/14 indicated client #9 had last made eye contact with staff	W000192	All staff received aretraining on 4-14-14 from the residential nurse/CPR instructor in the CPRtechniques which stressed "the most effective CPR position for theperson is on their back on a flat firm surface. If the person is on a sofa, chair or bed move them to a firm flat surface before youbegin CPR." Staff then demonstrated how to pull a person out of a chair in order to show the CPR instructor that they fullycomprehended the concept of where to preform CPR. The manager willask staff where and	05/17/2014

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>at 11:15 AM and was unresponsive when staff prompted him to eat lunch at 11:28 AM. Staff started CPR and called 911. Paramedic staff transported client #9 to the hospital and after resuscitation attempts were unsuccessful, client #9 was pronounced dead at 12:25 PM.</p> <p>The Residential Director was interviewed on 4/15/14 at 4:10 PM and indicated client #9's relative indicated their family had a history of heart attacks which was previously unknown to facility staff.</p> <p>A Mortality Review for client #9 was reviewed on 4/16/14 at 12:50 PM. A death certificate dated 3/20/14 indicated client #9 died on 3/15/14 and the cause of death for client #9 was "subacute myocardial infarction (heart attack) and severe coronary arteriosclerosis (plaque build up in the arteries)." A Conclusion of Internal Mortality Investigation signed on 4/14/14 indicated on 3/15/14 client #9 had been assisted by staff to take a shower and dress at 9:30 AM and returned to the living room where he was assisted into a recliner. "Staff recall interacting with him in the living room periodically and that he was pointing at the TV and making vocalizations." Client #9 lifted his head and looked at staff #7 at 11:15 AM. Staff #1 tapped client #9's leg (time unspecified) to prompt him to eat lunch and client #9 did not respond. When client #9 did not respond when tapped again and his arm fell when lifted, staff #1 "yelled for help" and staff #7 "checked his pulse and ran to get the phone. [Staff #1] reclined the chair and [staff #7] handed [staff #1] the phone and began CPR. 911 was contacted and staff indicated to the dispatch and EMT (emergency medical technician) assistant that they were doing CPR. Staff were</p>		<p>how to perform CPR on a monthly basis in order to ensure that this training was effective. This will be documented on the monthly house meeting minutes which are turned into the residential director for review. This will be an ongoing topic at the house meetings for the next year.</p>	

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	<p>instructed to lower [client #9] onto the floor and continue CPR until paramedics arrived. The EMS was dispatched at 11:30 AM and arrived at the group home at 11:36 AM." Recommendations of the investigation indicated "Staff did not move [client #9] to the most effective position before beginning CPR. [Client #9] was on a recliner, which the staff reclined to a flat position, but they did not lower [client #9] to the floor prior to beginning CPR. The CPR manual states 'For chest compressions to be the most effective, the person should be on his or her back on a firm, flat surface before you begin.' [Client #9] was lowered to the floor at the instruction of the 911 dispatcher. All staff will received (sic) re-training from a certified CPR instructor regarding optimal positions for administering CPR and what to do if a distressed consumer is not in an optimal position."</p> <p>Staff training records included in the Mortality Review indicated staff #1 was trained in CPR techniques on 2/28/13 and staff #7 had been trained on CPR techniques on 11/26/12 by the group home nurse.</p> <p>The group home nurse was interviewed on 4/16/14 at 3:00 PM and indicated staff had started CPR prior to moving client #9 to the floor which was not part of the training they had received in CPR. She indicated all of the group home staff had been retrained in CPR techniques.</p> <p>Staff training records were reviewed on 4/16/14 at 4:30 PM and indicated the residential manager and staff #1, #2, #3, #4, #5, #6 and #7 had been retrained on CPR techniques on 4/14/14.</p> <p>9-3-3(a)</p>						