

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G795		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 9228 W CR 950 N ELIZABETHTOWN, IN 47232			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: April 15, 16 and 17, 2013.</p> <p>Facility number: 0012547 Provider number: 15G795 AIM number: 201017690</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 17, 2013 by Dotty Walton, Medical Surveyor III.</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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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 4 clients living in the group home (#2, #3 and #4), the facility failed to keep an accurate accounting of the clients' funds.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 4/16/13 at 8:43 AM.</p> <p>Client #2's Cash on Hand ledger, dated April 2013, indicated client #2 had \$22.09. When the Team Leader (TL) counted the money there was \$23.08. The TL updated the April 2013 Cash on Hand ledger after counting the money to indicate there was \$23.08 in the account however she did not document the reason for the discrepancy or review the receipts (receipts were not in the home at the time of review). The Cash on Hand ledger, dated November 2012, indicated on 11/11/12 at 2:00 PM the amount in client #2's account was \$61.79. At 3:00 PM on 11/11/12, the amount changed to \$62.11 with no documentation of the deposit. On 12/18/12 at 2:00 PM, the amount in client #2's Cash on Hand was zero after a</p>	W000140	<p>W 140 Client Finances Corrective action for resident(s) found to have been affected Management staff will conduct a thorough accounting in the home to ensure that the correct balances are recorded on the client finance ledgers and that the amounts match how much cash actually is on hand for each client. In order to have client money readily available to them in the home, DSP staff members maintain some responsibility for proper accounting on a day-to-day basis. The Team Leader is the lead staff member who takes the primary role in this accounting. The Team Leader will be trained by management staff on proper accounting and ensuring that the correct amount of money is accounted for on the client finance ledger, which matches the actual amount of cash on hand for each client. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Account balancing in the home by management staff</p>	05/17/2013			

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	<p>withdrawal of \$42.11. On 12/18/12 at 4:00 PM, the "Amount in box" was \$1.77 with no documentation money was returned. On 1/6/13 at 11:00 AM, the amount was noted to be \$2.08. There was no documentation of a deposit between 12/18/12 and 1/6/13.</p> <p>Client #3's Cash on Hand ledger, dated April 2013, indicated client #3 had \$53.04. When the TL counted the money in client #3's account, there was \$52.78. On 4/15/13, client #3's account indicated he had \$47.44 after withdrawing \$10.00. Client #3 spent \$6.40 and returned \$3.60 to his account. The balance indicated a total of \$53.04. On 3/19/13, client #3 had a balance of \$0.87. The ledger indicated \$125.00 was added to his account and then \$100.00 was withdrawn. Client #3 spent \$66.04 of the \$100.00. The ledger indicated \$33.96 was added to account. The balance indicated \$59.15. On 2/22/13 at 11:00 PM, client #3's account had a balance of \$0.22. The account indicated client #3 spent \$6.40 and then the balance was noted to be \$0.87.</p> <p>Client #4's Cash on Hand ledger, dated April 2013, indicated client #4 had \$72.43. When the TL counted the money in client #4's account, there was \$66.43. On 3/19/13, client #4 had a balance of \$105.04. The ledger indicated he</p>		<p>and training of Team Leader in keeping accounting accurate and up-to-date. How corrective actions will be monitored to ensure no recurrence The Team Leader is the DSP who is responsible for day-to-day account balancing in the home. She is supervised by the Group Home Manager. Management staff, including the Group Home Manager and QDDP, provide training to all DSP staff. Management staff members are supervised by the Director who meets with them on a regular basis and monitors both training needs and finances.</p>				

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	<p>withdrew \$40.00, spent \$34.11 and returned \$6.00. The balance indicated \$71.36. On 3/25/13, the ledger indicated there was a balance of \$71.36. Client #4 withdrew \$40.00. The ledger indicated the balance was \$31.33.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/16/13 at 8:52 AM. The QIDP indicated the facility should account for the clients' finances to the penny.</p> <p>An interview with the Resident Manager (RM) was conducted on 4/16/13 at 10:45 AM. The RM indicated the direct care staff were responsible with counting the clients' finances two times per day. The RM indicated she most recently counted the money 3 weeks ago and there were no issues noted. The RM indicated she was not notified of discrepancies with the clients' finances.</p> <p>An interview with the Team Leader (TL) was conducted 4/16/13 at 8:43 PM. The TL indicated client #2's actual cash on hand did not match the ledger due to client #2 finding money and putting it into his account without the money being accounted for. The TL indicated the clients' cash on hand did not match the ledgers due to the direct care staff</p>						

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	<p>combining the clients' money after outings. The TL indicated the money should not be combined. The TL indicated client #4's cash on hand did not match the ledger due to the TL adding the amount from a ice cream store's gift card into the amount in his cash on hand. The TL initially indicated the amount she added to client #2's cash on hand ledger to account for the gift card was \$6.00. The TL then indicated the amount was \$7.30. The TL called the number on the gift card to get the actual total and it was \$11.69. The TL indicated the staff told her the amount left on the card was \$6.00. The TL indicated she was not keeping an accounting on a separate form for the gift card. The QIDP informed the TL during the interview the TL needed to keep a separate accounting of the gift card.</p> <p>On 4/16/13 at 7:29 PM, the QIDP indicated in an email, "After several hours we were able to make sense of the client finances. I have attached the corrected forms and proof the TL was retrained on procedures."</p> <p>9-3-2(a)</p>						

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W000149	<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 for 12 of 30 incident/investigative reports reviewed affecting 3 of 4 clients living in the group home (#1, #2 and #4), the facility neglected to implement its policies and procedures to prevent client to client abuse, staff neglect involving a client taking another client's medications and failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/15/13 at 12:29 PM.</p> <p>1. On 6/1/12 at 2:00 PM, client #1 took the remote from client #4 and then kicked him in the abdomen. Client #4 was not injured. The facility unsubstantiated abuse. The report indicated, "The physical aggression did occur between [client #1] and [client #2] and [client #1] was the aggressor. [Client #1] struggles with impulse issues and has the diagnosis of Intermittent Explosive Disorder. The evidence suggested that this was an impulsive act on the part of [client #1]. [Client #2] is also a new resident in the</p>	W000149	<p>W 149 Peer-to-Peer Aggression and Medication Error Investigation Corrective action for resident(s) found to have been affected Peer aggression will be addressed through a staff training on prevention of behavior problems and proper spacing of staff with a focus on keeping individuals safe. Training will be conducted by a certified trainer in Mandt, which is the system of de-escalation and physical intervention used by the residential provider. The incident where a client refused his medication then later went to the area where medications were being administered and took the medications for a different client was viewed as a medication error rather than neglect. After review, it was determined that the staff member was exhibiting a trend of poor performance, which led to termination. Upon further reflection, this incident has the potential to be viewed as neglect since the staff member did not secure the medication or prevent the wrong person from taking it. The QDDP conducts investigations and reports findings to the Director. The Director will conduct a training with the QDDP that focuses on identifying when to interpret an</p>	05/17/2013			

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	<p>home and is large in stature and it appears that [client #1] may have been trying to assert his place in the social hierarchy of the home and used bad judgment in doing so." The investigative report did not contain a description of the incident of client to client aggression.</p> <p>2. On 7/20/12 at 10:30 AM at the facility-operated day program, client #1 pushed a female peer from another group home to the floor. The facility substantiated abuse.</p> <p>3. On 8/3/12 at 1:30 PM, client #1 demanded client #2 to get off the computer to help clean. Client #1 pushed client #2 in the face. Client #2 grabbed client #1 by the neck and hit him in the eye with his fist. Clients #1 and #2 fell to the floor. Client #2 had a small abrasion on his knee from falling. Client #1 had a small bruise under his eye and rug burn on his knee and arm. The facility substantiated abuse.</p> <p>4. On 8/29/12 at 12:30 PM at the facility-operated day program, client #1 elbowed a female peer from another group home in the arm. The female peer was not injured. The facility substantiated abuse.</p> <p>5. On 11/2/12 at 4:40 PM, client #2 was</p>		<p>incident as possible neglect or violation of client rights, and that in such circumstances, a full investigation is required. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Staff training to prevent peer-to-peer aggression and QDDP training on when an incident is considered neglect, which requires a full investigation. How corrective actions will be monitored to ensure no recurrence DSP staff members are supervised and trained by management staff members, some of whom are certified Mandt trainers. All management staff members are supervised by the Director who meets with them regularly. During these meetings, training requirements are reviewed. In addition, the Director, a Compliance Officer, and an agency Vice President meet regularly as an Incident Oversight Committee that reviews all incident reports and monitors investigations, IDT actions, and corrective action put in place to prevent recurrence of incidents.</p>				

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	<p>eating dinner with client #1. Client #1 told client #2 to slow down. Client #2 stood up, apologized to staff prior to the incident, grabbed client #2 around the neck with both arms, and pushed client #1 out of his chair causing him to fall on the floor. Client #2 ended up on top of client #1 on the floor. Client #1 sustained a small abrasion on his forehead. The facility substantiated abuse.</p> <p>6. On 11/15/12 at 4:00 PM, client #2 struck client #1, knocked him to the ground and kicked him several times. The facility substantiated abuse.</p> <p>7. On 12/30/12 at 1:45 PM, client #2 was standing in front of the television. Client #1 asked him to move. Client #2 told client #1 to wait. Client #1 pushed an ottoman with his foot into client #2. Client #2 stood up and attempted to hit client #1. Client #2 pushed past staff and pushed client #2. Both clients fell over a recliner and onto the floor. Two staff restrained client #2. As the two staff were escorting client #2, he kicked client #1 in the face. Client #2 complained of shoulder pain from the fall. Client #1 had a cut lip. He was diagnosed with a contusion. The facility substantiated abuse.</p> <p>8. On 2/2/13 at 6:15 PM, client #1 struck</p>						

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	<p>client #4 with his hand near client #4's neck. The investigative report, dated 2/8/13, indicated staff was in between the clients when client #1 reached over staff and hit client #4. Client #1 was restrained. The facility substantiated abuse.</p> <p>9. On 2/13/13 at 8:00 AM, client #4 was banging on doors and walls. Client #1 woke up, rushed from his room and grabbed client #4 by his neck and shouted, "I told you to shut up." Client #4 had a small red mark on his neck. The facility substantiated abuse.</p> <p>10. On 2/13/13 at 4:45 PM, client #1's radio was not working. Client #4 ran past client #1 and laughed. Client #1 slapped client #4 in the face. The facility substantiated abuse.</p> <p>11. On 3/5/13 at 8:00 AM, client #2 went into the medication area after former direct care staff #11 had prepared another client's (#4) medications. Client #2 took client #4's medications before staff #11 was aware client #2 entered the medication area. Staff #11 notified the nurse 45 minutes after the error occurred. On 3/5/13 at 4:00 PM, staff went in to check on client #2 to take his vitals due to taking another client's medications. After 15 minutes, client #2 woke up and</p>				

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	<p>allowed staff to take his vitals. Client #2 was sweaty and his blood pressure was 137/69. His pulse was 122. The nurse was contacted and 911 was called. Client #2 was responsive with the paramedics. The hospital did an EKG (electrocardiogram) and blood work. Both tests found no abnormalities. Staff #11 who was involved was terminated on 3/15/13. The facility's nurse conducted a review of the medication error on 3/6/13. The facility did not provide documentation an investigation was conducted.</p> <p>12. On 4/13/13 at 8:10 AM, clients #1 and #2 were walking back to their rooms after breakfast. Client #2 indicated to client #1, "Hey sweetie." Client #1 hit client #2 in the face. Client #2 hit client #1 and grabbed client #1 by his neck. Both clients fell to the floor. Client #2 struck client #1 "several" more times. Three staff intervened and took "approximately" 2 minutes to get the clients separated. Client #2 had scratches and red areas on his neck. Client #1 had bruises on his knees, neck and forehead and complained initially of having difficulty breathing but resumed normal activity "within a short time." The nurse was notified. The facility was conducting an investigation.</p>						

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	A review of the facility's Group Home Abuse and Neglect policy, dated 12/5/12, was conducted on 4/15/13 at 12:29 PM. The policy indicated, in part, "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse. Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Neglect includes failure to provide appropriate care, food, medical care or supervision. If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place. If the charges are substantiated disciplinary action will be taken which may include termination. Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities." The policy indicated, "Failure to report suspected abuse is considered neglect and directly against agency policy and an employee will be guilty of an infraction if not reported within a reasonable time frame. Serious medication errors as defined by						

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	<p>the individual's physician as jeopardizing the individual's health and safety, will be investigated as possible neglect. Failure to report an (sic) abuse is also considered neglectful." The policy indicated, "AWS will complete an internal investigation of allegation of abuse, neglect or exploitation to determine wrongdoing, training needs and/or improve communication among the IDT (interdisciplinary team)."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/15/13 at 2:14 PM. The QIDP indicated client to client aggression was abuse. The QIDP indicated the facility had a policy prohibiting abuse and neglect of the clients. The QIDP indicated the 6/1/12 incident contained a description of the incident in the investigative packet within the Bureau of Developmental Disabilities Services incident reports. The QIDP indicated the investigative form was revised after the incident to ensure all information was included within the investigation. The QIDP indicated each incident of client to client aggression was unique. The QIDP indicated the clients' IDTs met following each incident of client to client abuse. The QIDP indicated client #1 typically exhibited no precursors prior to client to client</p>			

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	<p>aggression and it was difficult to prevent. The QIDP indicated the staff involved in the medication error on 3/5/13 was terminated for not following policies. The QIDP indicated the staff prepared client #2's medications, he refused to take them and indicated he would be in later to take them. The staff put client #2's medications to the side, unlocked. The staff prepared another client's medications. Client #2 went into the medication room unannounced and took the medications. The QIDP indicated the staff had other medication errors previously. The QIDP indicated for the medication error on 3/5/13 involving client #2 an investigative report was not filled out. The QIDP indicated the IDT (interdisciplinary team) met and determined it was not neglect. The QIDP indicated an internal investigation was conducted but not put on the investigative report. The QIDP indicated an investigative report should have been completed. The QIDP stated "We did everything we were supposed to we just didn't put it on the form."</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 30 incident/investigative reports affecting 2 of 4 clients living in the group home (#1 and #2), the facility failed to conduct thorough investigations of client to client abuse and staff neglect resulting in a client taking medications prescribed for another client.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/15/13 at 12:29 PM.</p> <p>1. On 6/1/12 at 2:00 PM, client #1 took the remote from client #2 and then kicked him in the abdomen. Client #2 was not injured. The facility unsubstantiated abuse. The report indicated, "The physical aggression did occur between [client #1] and [client #2] and [client #1] was the aggressor. [Client #1] struggles with impulse issues and has the diagnosis of Intermittent Explosive Disorder. The evidence suggested that this was an impulsive act on the part of [client #1]. [Client #2] is also a new resident in the home and is large in stature and it appears that [client #1] may have been trying to</p>	W000154	<p>W 154 Investigation of Med Error and Peer Abuse. Corrective action for resident(s) found to have been affected The incident where a client refused his medication then later went to the area where medications were being administered and took the medications for a different client was viewed as a medication error rather than neglect. After review, it was determined that the staff member was exhibiting a trend of poor performance, which led to termination. Upon further reflection, this incident has the potential to be viewed as neglect since the staff member did not secure the medication or prevent the wrong person from taking it. The QDDP conducts investigations and reports findings to the Director. The Director will conduct a training with the QDDP that focuses on identifying when to interpret an incident as possible neglect or violation of client rights, and that in such circumstances, a full investigation is required. The incident of peer abuse that resulted in a finding that the abuse was unsubstantiated did not contain a description of the incident (it is notable, however, that the actual incident report was</p>	05/17/2013			

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	<p>assert his place in the social hierarchy of the home and used bad judgment in doing so." The investigative report did not contain a description of the incident of client to client aggression.</p> <p>2. On 3/5/13 at 8:00 AM, client #2 went into the medication area after former direct care staff #11 had prepared another client's (#4) medications. Client #2 took client #4's medications before staff #11 was aware client #2 entered the medication area. Staff #11 notified the nurse 45 minutes after the error occurred. On 3/5/13 at 4:00 PM, staff went in to check on client #2 to take his vitals due to taking another client's medications. After 15 minutes, client #2 woke up and allowed staff to take his vitals. Client #2 was sweaty and his blood pressure was 137/69. His pulse was 122. The nurse was contacted and 911 was called. Client #2 was responsive with the paramedics. The hospital did an EKG (electrocardiogram) and blood work. Both tests found no abnormalities. Staff #11 was terminated on 3/15/13. The facility's nurse conducted a review of the medication error on 3/6/13. The facility did not provide documentation an investigation was conducted.</p> <p>An interview with the Qualified Intellectual Disabilities Professional</p>		<p>attached to the investigation). The investigation training by the Director will include instructions to the QDDP that (a) every investigation must include a summary of the incident being investigated, and (b) that whenever physical contact is made between peers, the finding of abuse must be substantiated. How facility will identify other residents potentially affected & what measures taken All residents potentially affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence QDDP training on investigations, including when an incident is considered neglect, that a summary of the incident is required in all investigations, and that peer abuse must be substantiated whenever physical contact is made between clients. How corrective actions will be monitored to ensure no recurrence All management staff members are supervised and trained by the Director who meets with them regularly. The Director, a Compliance Officer, and an agency Vice President meet regularly as an Incident Oversight Committee that reviews all incident reports and monitors investigations, IDT actions, and corrective action put in place to prevent recurrence of incidents.</p>				

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	<p>(QIDP) was conducted on 4/15/13 at 2:14 PM. The QIDP indicated the 6/1/12 incident contained a description of the incident in the investigative packet within the Bureau of Developmental Disabilities Services incident reports. The QIDP indicated the investigative form was revised after the incident to ensure all information was included within the investigation. The QIDP indicated for the medication error on 3/5/13 involving client #2 an investigative report was not filled out. The QIDP indicated the IDT (interdisciplinary team) met and determined it was not neglect. The QIDP indicated an internal investigation was conducted but not put on the investigative report. The QIDP indicated an investigative report should have been completed. The QIDP stated "We did everything we were supposed to we just didn't put it on the form."</p> <p>9-3-2(a)</p>				