

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/30/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2405 S CR 200 N NORTH VERNON, IN 47265		
(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	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 26, 27 and 30, 2013</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>Facility Number: 004132 Provider Number: 15G717 Aims Number: 200494750</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/9/13 by Ruth Shackelford, 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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W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on observation and interview for 1 of 2 sampled clients (client #1), the facility's nursing services failed to ensure staff followed proper procedures in disposing of a dropped pill.</p> <p>Findings include:</p> <p>During the medication administration observation on 9/26/13 at 6:00 PM, Client #1 came into the medication room at 6:20 PM. Staff #5 popped client #1's Ferrous Sulfate (iron) out of the bubble pack at 6:22 PM. The pill fell on the cabinet counter top, staff #5 picked it up and deposited it in the plastic medicine cup. Staff #5 put the pill in applesauce and gave it to client #1. The cabinet counter had not been sanitized between clients.</p> <p>Interview with staff #3, LPN (Licensed Practical Nurse) on 9/30/13 at 11:30 AM indicated the medication should have been disposed of as contaminated and a new pill should have been dispensed.</p> <p>9-3-6(a)</p>	W000340	Staff #5 will not be permitted to continue to pass medication until retraining occurs. Retraining for this individual will include a review of Core A medication administration procedures with the AWS Nurse. Following retraining, a successful demonstration by Staff #5 of medication administration skills will be completed and documented on a Medication Skills Checklist as observed by the AWS Nurse. All AWS direct care staff in this home will receive review instructions from the AWS Nurse regarding proper medication administration procedures as outline in Core A medication administration training.	10/30/2013			

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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. Based on observation, record review and interview for 1 of 4 clients residing in the home, (client #3), the facility failed to ensure the client's medication was administered at the prescribed time.</p> <p>Findings include:</p> <p>During the medication administration observation on 9/26/13 at 6:00 PM, client #3 received calcium at 6:00 PM. Staff #5 administered the medication.</p> <p>The Medication Administration Record dated 9/2013 was reviewed on 9/27/13 at 8:45 AM. The Medication Administration Record indicated the calcium was to be administered at 8:00 PM. The physician orders dated 9/2013 were reviewed on 9/27/13 at 9:00 AM and indicated the calcium should have been administered at 8:00 PM.</p> <p>The Medication Administration Policy with a revision date of May 8, 2008 was reviewed on 9/30/13 at 11:30 AM. The policy indicated "Employees are responsible to administer medication within 1/2 hour before or 1/2 hour after the prescribed time on the Medication</p>	W000368	Staff #5 will not be permitted to continue to pass medication until retraining occurs. Retraining for this individual will include a review of Core A medication administration procedures with the AWS Nurse. Following retraining, a successful demonstration by Staff #5 of medication administration skills will be completed and documented on a Medication Skills Checklist as observed by the AWS Nurse. All AWS direct care staff in this home will receive review instructions from the AWS Nurse regarding proper medication administration procedures as outline in Core A medication administration training.	10/30/2013			

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	Administration Record." Interview with Staff #3, LPN, on 9/30/13 at 11:45 AM indicated the calcium for client #3 should have been administered at 8:00 PM. 9-3-6(a)				