

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G714	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 100 S CR 265 W NORTH VERNON, IN 47265
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W000000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00145859.</p> <p>Complaint #IN00145859: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W331 and W369.</p> <p>Dates of Survey: April 1, 2, 3, 4 and 11, 2014.</p> <p>Surveyor: Vickie Kolb, RN</p> <p>Facility Number: 003993 Provider Number: 15G714 AIM Number: 200474890</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general</p>			

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>policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to exercise general policy and operating direction over the facility:</p> <p>__To ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all allegations of neglect and injuries of unknown origin were investigated, reported immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law for clients B and C.</p> <p>__To ensure all facility and day program staff were trained/retrained to recognize and immediately report neglect.</p> <p>__To ensure the facility maintained the temperature in client A's, B's, C's and D's bedrooms and bathrooms within a normal comfort range, above 68 degrees F (Fahrenheit).</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in</p>	W000104	All AWS staff and supervisors at this AWS group home and AWS day program will receive training regarding the definition of abuse, neglect and, injuries of unknown origin, as well as the appropriate steps to take when reporting and investigating. This training will be competency based to ensure all staff are able to demonstrate an understanding of the training content. The AWS Director will ensure that all training is completed and documented. All AWS staff and supervisors at this AWS group home will receive training regarding maintaining room temperatures within a normal comfort range. AWS supervisory staff will monitor room temperatures on an ongoing basis to ensure they are appropriate. Addendum: AWS Manager, Team Leader, and QDDP will each check the room temperature during weekly visits to the home.	05/11/2014			

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	<p>regard to allegations of neglect for clients B and C, to ensure all injuries of unknown origin were investigated for client C and to ensure all staff were trained/retrained in regard to identifying neglect and immediately reporting the neglect to the administrator. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of neglect were reported immediately to the facility administrator and to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law for clients B and C. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of neglect and all injuries of unknown origin were thoroughly investigated for clients B and C. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff were trained/retrained to recognize and report neglect immediately to the administrator for clients B and C. Please see W189.</p>			

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W000130	<p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility maintained the temperature in client A's, B's, C's and D's bedrooms and bathrooms within a normal comfort range (68 or above) degrees F (Fahrenheit). Please see W429.</p> <p>9-3-1(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 additional client (C), the facility failed to ensure the client's privacy while providing the client's medications and nourishments.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/2/14 between 5:30 AM and 8:40 AM. At 7:35 AM DCS (Direct Care Staff) #4 pushed client C in her wheel chair up to the dining room table and lifted client C's top. DCS #4 then lowered the front of client C's pants to</p>	W000130	<p>All staff at this AWS group home will receive retraining regarding the appropriate method for providing privacy to clients when they are receiving medication and feedings. AWS supervisors and Nurses will monitor staff on an ongoing basis to ensure client privacy is occurring.</p> <p>Addendum: AWS Supervisors (Manager, QDDP, Team Leader) will each monitor staff to ensure protection of client privacy during weekly staff/client interaction observation checks.</p>	05/11/2014

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	<p>expose her abdomen from below her breasts to below her belly button and to expose client C's abdominal stoma which was red and irritated. DCS #4 stated, "We're putting medicine on that." DCS #4 continued to given client C her morning medications and morning feeding. Client A was sitting in his wheelchair at the dining room table beside client C and client B was in the living room in a wheelchair and facing the television. While giving client C her feeding, client D wheeled past client C and into the kitchen area. DCS #4 did not provide client C with a cloth to cover her abdomen while giving client C her morning medications and feeding.</p> <p>Interview with the RN on 4/3/14 at 3 PM indicated the staff were to provide client C privacy while giving client C her morning medications and feeding. The RN stated the staff were trying to give client C a "sense of normalcy" in having her be in the dining area while receiving her feeding. The RN stated the DCS "should have provided" client C with a towel or cloth to cover her exposed abdomen while giving client C her morning medications and feeding.</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 1 of 2 sampled clients (B) and 1 additional client (C), the facility failed to implement written policy and procedures to ensure the facility conducted a thorough investigation in regard to allegations of neglect for clients B and C, to ensure all injuries of unknown origin were investigated for client C and to ensure all staff were trained/retrained in regard to identifying neglect and immediately reporting the neglect to the administrator.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 4/2/14 at 1 PM. The facility records indicated a BDDS (Bureau of Developmental Disabilities Services) report dated 7/31/13.</p> <p>1. The report indicated "[Name of two clients and client B] attend an AWS Day Service Program in [name of city and town.] On 7-30-13 at 12:40 pm the staff at Day Services that was assigned to these clients [Day Program (DP) staff #3] was seen sleeping sitting at a table in the</p>	W000149	All AWS staff and supervisors at this AWS group home and AWS day program will receive training regarding the definition of abuse, neglect and, injuries of unknown origin, as well as the appropriate steps to take when reporting and investigating. This training will be competency based to ensure all staff are able to demonstrate an understanding of the training content. The AWS Director will ensure that all training is completed and documented. Addendum: The AWS Director will review all incident reports to insure that appropriate reporting and investigation procedure is completed.	05/11/2014	

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	<p>room with the clients. Day Service staff reported this incident to Day Service Program Manager and [DP staff #3] was suspended from work on 7/30/13 until investigation is completed." The report indicated the plan to resolve immediate and long term issues was to "Complete an investigation concerning staff sleeping while at Day Services. Receive written statements from staff working that day at Day Services." The investigative report dated 8/2/13 indicated "Two AWS employees, [DP staff #1 and DP staff #2] reported that they witnessed [DP staff #3] sleeping while she was supposed to be working with 3 AWS clients at the Day Program. [DP staff #1], the Activity Coordinator, did not immediately wake [DP staff #3] or suspend her after witnessing that she was sleeping. [DP staff #1] will receive retraining regarding the appropriate process to follow in a similar occurrence." The report indicated date of knowledge of the allegation was 7/31/13.</p> <p>The investigative report indicated the following statements: A statement from DP staff #1 dated 8/1/13 indicated "On July 30, 2013 at 12:45 pm I found [DP staff #3] asleep at the table for about six minutes." An undated statement from DP staff #2</p>				

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	<p>indicated "I saw [DP staff #3] sleeping about 15 minutes at 12:45 on 7/30/13."</p> <p>A statement from DP staff #3 dated 8/2/13 indicated "I [DP staff #3] did not fall asleep at work. I have been in trouble for this before so why would I do it again. I love my job and I have been doing good so why would I mess this up. My job means everything to me."</p> <p>The investigative report indicated "Based on the findings of the investigation... [DP staff #3] employment with AWS was suspended on 7-30-13. On 8-2-13 her employment with AWS was terminated. The Supervisors at the AWS Day Program will receive retraining regarding the appropriate action to take in case of future similar incidents."</p> <p>The investigative records indicated no additional staff interviews, no client interviews and no record reviews (employee files, DP staffing records, etc.)</p> <p>The facility records indicated the facility failed to conduct a thorough investigation in regard to the allegations of neglect of 7/30/13.</p> <p>The retraining of staff in regard to the allegations of neglect of 7/30/13 was requested. The QIDP (Qualified</p>			

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	<p>Intellectual Disabilities Professional) provided a "Record of Training dated 8/21/13 for the QIDP, DP staff #6 and the Residential Manager (RM). The training indicated "If an employee is witnessed to be sleeping on the job, they should be sent home immediately and suspended until an investigation is completed. When an employee is sleeping while they are supposed to be working with clients, it is considered neglect. Do not let the staff continue to sleep, but address the issue immediately. There should be no discussion with Direct Support Employees regarding the performance of other staff. If a DSP (Direct Support Professional) states a concern or issue with the performance of another DSP, take notes and ask them to document the concern or issue. Do not make comments about the possible consequences or any personal feelings you may have about the action or individual. There should be no discussion or staff discipline issues with employees who are not directly involved in a supervisory capacity."</p> <p>The facility records failed to indicate all facility staff were trained/retrained in regard to the appropriate action to take when a staff is found sleeping.</p> <p>During interview with the QIDP on 4/3/14 at 3 PM, the QIDP stated he was</p>			

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	<p>"in charge" of the Day Program. The QIDP indicated a staff sleeping while on duty was considered neglect. The QIDP indicated he had completed the BDDS report and the report indicated date of knowledge of the incident was 7/31/13. The QIDP stated "I can't remember who reported the incident or when it was reported." The QIDP stated DP staff #1 was the supervisor at the DP at the time of the incident and DP staff #1 was "supposed to be" retrained in regard to staff sleeping while on the job. The QIDP stated "I don't know where [DP staff #1's] documentation of training is."</p> <p>During interview with DP staff #1 on 4/4/14 at 10:45 AM, DP staff #1 indicated another staff had seen DP staff #3 sleeping as well as herself. DP staff #1 indicated she tapped DP staff #3 on the shoulder and told her, "You need to wake up." DP staff #1 indicated DP staff #3 woke up, began moving around and went outside to smoke a cigarette. DP staff #1 indicated DP staff #3 was not immediately suspended from working but had finished her shift on 7/30/13 and had returned to work the following day. DP staff #1 indicated she did not immediately report the DP staff #3's sleeping while at work but had reported it to the RM sometime later. DP staff #1 indicated she could not remember when</p>			

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	<p>she reported it. DP staff #1 stated DP staff #3 was suspended for three days "sometime the following week" and then she [DP staff #3] returned to work after her suspension for "one or two weeks after that." DP staff #1 indicated no additional training was provided to the staff in regard to staff sleeping at work.</p> <p>2. The facility Report of Injury (IR) dated 9/18/13 indicated the staff noted a 1 inch scratch on client C's left ear lobe. The IR indicated "ear was bloody." The report indicated "It appears the ear may have stayed wet and cracked." The facility records indicated no investigation in regard to the injury of unknown origin for client C.</p> <p>3. The IR dated 11/8/13 at 5 AM indicated "While getting client [C] up with the lift - somehow she [client C] slipped out of the lift and fell onto the floor. Checked her over for apparent injuries but could not find any." The IR indicated the QIDP instructed the staff to monitor the client for injuries and to notify the DP so they too could observe for possible injury. The report indicated "apparently one of the connections came loose when lifted up. Will double check connections after getting person into lift - triple check connections because I already double checked connections."</p>			

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	<p>The IR indicated the QIDP was on his way to the home and also checked the client for injury and found none.</p> <p>Interview with the QIDP on 4/3/14 at 11 AM indicated staff #3 had called him at home in regard to the incident of 11/8/13. The QIDP indicated he lived close by the group home and went to the group home to assist staff #3 to get client C up off of the floor. When asked what happened, the QIDP stated "I think the sling was the wrong size or something. She [staff #3] might have used the wrong one. It's on the report." When asked was the incident reported to BDDS/APS (Adult Protective Services) and was there an investigation conducted, the QIDP stated, "No, I was here right after it happened. She [client C] wasn't hurt." The QIDP indicated no investigation was conducted and the incident was not reported to BDDS/APS.</p> <p>Interview with the facility administrator on 4/1/14 at 2 PM indicated all allegations of neglect and injuries of unknown origin were to be investigated. The facility administrator indicated all allegations of neglect were to be reported to BDDS and to APS as indicated by state law.</p> <p>The revised "Group Home Abuse and Neglect" policy dated 08/08 reviewed on</p>			

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	<p>4/2/14 at 1 PM. indicated:</p> <p>___ Neglect to include "failure to provide appropriate care, food, medical care or supervision."</p> <p>___ "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. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protective Services, and client representatives...."</p> <p>___ "If an AWS employee is accused of abuse, neglect or exploitation they will be sent home without pay or reassigned to a position in which there is not contact with individuals receiving services until a preliminary investigation is completed and appropriate safeguards are put into place."</p> <p>___ The facility policy did not include injuries of unknown origin were to be reported immediately to the administrator and investigated.</p> <p>9-3-2(a)</p>			
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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 2 of 2 allegations of neglect for clients B and C, the facility failed to ensure all allegations of neglect were reported immediately to the facility administrator and to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>Findings include:</p> <p>1. The facility's reportable records were reviewed on 4/2/14 at 1 PM. The facility records indicated a BDDS (Bureau of Developmental Disabilities Services) report dated 7/31/13. The report indicated "[Name of two clients and client B] attend an AWS Day Service Program in [name of city and town.] On 7-30-13 at 12:40 pm the staff at Day Services that was assigned to these clients [Day Program (DP) staff #3] was seen sleeping sitting at a table in the room with the clients. Day Service staff reported this</p>	W000153	<p>All AWS staff and supervisors at this AWS group home and AWS day program will receive training regarding the definition of abuse, neglect and, injuries of unknown origin, as well as the appropriate steps to take when reporting and investigating. This training will be competency based to ensure all staff are able to demonstrate an understanding of the training content. The AWS Director will ensure that all training is completed and documented.</p> <p>Addendum: The AWS Director will review all incident reports to insure that appropriate reporting and investigation procedure is completed.</p>	05/11/2014
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	<p>incident to Day Service Program Manager and [DP staff #3] was suspended from work on 7/30/13 until investigation is completed." The report indicated the plan to resolve immediate and long term issues was to "Complete an investigation concerning staff sleeping while at Day Services. Receive written statements from staff working that day at Day Services." The investigative report dated 8/2/13 indicated "Two AWS employees, [DP staff #1 and DP staff #2] reported that they witnessed [DP staff #3] sleeping while she was supposed to be working with 3 AWS clients at the Day Program. [DP staff #1], the Activity Coordinator, did not immediately wake [DP staff #3] or suspend her after witnessing that she was sleeping. [DP staff #1] will receive retraining regarding the appropriate process to follow in a similar occurrence." The report indicated date of knowledge of the allegation was 7/31/13.</p> <p>The investigative report indicated the following statements: A statement from DP staff #1 dated 8/1/13 indicated "On July 30, 2013 at 12:45 pm I found [DP staff #3] asleep at the table for about six minutes." An undated statement from DP staff #2 indicated "I saw [DP staff #3]</p>						

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	<p>sleeping about 15 minutes at 12:45 on 7/30/13."</p> <p>The facility records indicated the allegation of neglect on 7/30/13 for client B was not immediately reported to the administrator.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 3 PM, the QIDP stated he was "in charge" of the Day Program. The QIDP indicated he had completed the BDDS report and the report indicated date of knowledge of the incident was 7/31/13. The QIDP stated "I can't remember who reported the incident or when it was reported." The QIDP stated DP staff #1 was the supervisor at the DP at the time of the incident.</p> <p>During interview with DP staff #1 on 4/4/14 at 10:45 AM, DP staff #1 indicated another staff had seen DP staff #3 sleeping as well as herself. DP staff #1 indicated she tapped DP staff #3 on the shoulder and told her, "You need to wake up." DP staff #1 indicated DP staff #3 woke up, began moving around and went outside to smoke a cigarette. DP staff #1 indicated she did not immediately report DP staff #3 for sleeping while at work but had reported it to the RM (Residential Manager) sometime later. DP staff #1</p>						

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	<p>indicated she could not remember when she reported the incident.</p> <p>2. The IR dated 11/8/13 at 5 AM indicated "While getting client [C] up with the lift - somehow she [client C] slipped out of the lift and fell onto the floor. Checked her over for apparent injuries but could not find any." The IR indicated the QIDP instructed the staff to monitor the client for injuries and to notify the DP so they too could observe for possible injury. The report indicated "apparently one of the connections came loose when lifted up. Will double check connections after getting person into lift - triple check connections because I already double checked connections." The IR indicated the QIDP was on his way to the home and the QIDP had also checked the client for injury and found none.</p> <p>The facility records indicated the incident of client C falling from the sling of a mechanical lift while being transferred was not reported to BDDS or APS.</p> <p>Interview with the QIDP on 4/3/14 at 11 AM indicated staff #3 had called him at home in regard to the incident of 11/8/13. The QIDP indicated he lived close by the group home and went to the group home to assist staff #3 in getting client C up off</p>						

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W000154	<p>of the floor and back into bed. When asked what happened, the QIDP stated "I think the sling was the wrong size or something. She [staff #3] might have used the wrong one." When asked was the incident reported to BDDS or APS the QIDP stated, "No, I was here right after it happened and she [client C] wasn't hurt."</p> <p>Interview with the facility administrator on 4/1/14 at 2 PM indicated all allegations of neglect were to be reported to BDDS and to APS as indicated by state law.</p> <p>9-3-2(a)</p> <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 2 allegations of neglect and 1 of 1 injury of unknown origin for clients B and C, the facility failed to ensure all allegations of neglect and all injuries of unknown origin were thoroughly investigated.</p> <p>Findings include:</p>	W000154	All AWS staff and supervisors at this AWS group home and AWS day program will receive training regarding the definition of abuse, neglect and, injuries of unknown origin, as well as the appropriate steps to take when reporting and investigating. This training will be competency based to ensure all staff are able to demonstrate an understanding of the training content. The AWS Director will ensure that all training is	05/11/2014	

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	<p>The facility's reportable and investigative records were reviewed on 4/2/14 at 1 PM. The facility records indicated a BDDS (Bureau of Developmental Disabilities Services) report dated 7/31/13.</p> <p>1. The report indicated "[Name of two clients and client B] attend an AWS Day Service Program in [name of city and town.] On 7/30/13 at 12:40 pm the staff at Day Services that was assigned to these clients [Day Program (DP) staff #3] was seen sleeping sitting at a table in the room with the clients. Day Service staff reported this incident to Day Service Program Manager and [DP staff #3] was suspended from work on 7/30/13 until investigation is completed." The report indicated the plan to resolve immediate and long term issues was to "Complete an investigation concerning staff sleeping while at Day Services. Receive written statements from staff working that day at Day Services." The investigative report dated 8/2/13 indicated "Two AWS employees, [DP staff #1 and DP staff #2] reported that they witnessed [DP staff #3] sleeping while she was supposed to be working with 3 AWS clients at the Day Program. [DP staff #1], the Activity Coordinator, did not immediately wake [DP staff #3] or suspend her after witnessing that she was sleeping. [DP staff #1] will receive retraining regarding</p>		<p>completed and documented. Addendum: The AWS Director will review all incident reports to insure that appropriate reporting and investigation procedure is completed.</p>	

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	<p>the appropriate process to follow in a similar occurrence." The report indicated date of knowledge of the allegation was 7/31/13.</p> <p>The investigative report indicated the following statements:</p> <p>A statement from DP staff #1 dated 8/1/13 indicated "On July 30, 2013 at 12:45 pm I found [DP staff #3] asleep at the table for about six minutes."</p> <p>An undated statement from DP staff #2 indicated "I saw [DP staff #3] sleeping about 15 minutes at 12:45 on 7/30/13."</p> <p>A statement from DP staff #3 dated 8/2/13 indicated "I [DP staff #3] did not fall asleep at work. I have been in trouble for this before so why would I do it again. I love my job and I have been doing good so why would I mess this up. My job means everything to me."</p> <p>The investigative records indicated no additional staff interviews, no client interviews and no record reviews (employee files, DP staffing records, etc.)</p> <p>The facility records indicated the facility failed to conduct a thorough investigation in regard to the allegations of neglect of 7/30/13.</p>						

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 11 AM indicated the facility administrator had conducted the investigation. The QIDP indicated all documentation in regard to the investigation of neglect of 7/30/13 had been provided for review.</p> <p>Telephone interview with the facility administrator on 4/3/14 at 11:30 AM indicated the DP staff that had observed DP staff #3 sleeping had provided written statements. The administrator stated, "Why would there be a need to conduct any other interviews? It was already substantiated." The facility administrator indicated all documentation in regard to the investigation of neglect of 7/30/13 had been provided for review.</p> <p>2. The facility Report of Injury (IR) dated 9/18/13 indicated the staff noted a 1 inch scratch on client C's left ear lobe. The IR indicated "ear was bloody." The report indicated "It appears the ear may have stayed wet and cracked." The facility records indicated no investigation in regard to the injury of unknown origin.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 11 AM indicated no investigation was conducted in regard to</p>			
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	<p>client C's injury of unknown origin. The QIDP indicated the staff did not see the injury to client C's ear.</p> <p>3. The IR dated 11/8/13 at 5 AM indicated "While getting client [C] up with the lift - somehow she [client C] slipped out of the lift and fell onto the floor. Checked her over for apparent injuries but could not find any." The IR indicated the QIDP instructed the staff to monitor the client for injuries and to notify the DP so they too could observe for possible injury. The report indicated "apparently one of the connections came loose when lifted up. Will double check connections after getting person into lift - triple check connections because I already double checked connections." The IR indicated the QIDP was on his way to the home and also checked the client for injury and found none. The facility records indicated no investigation in regard to client C falling out of the sling for a mechanical lift during transfer.</p> <p>Interview with the QIDP on 4/3/14 at 11 AM indicated staff #3 had called him at home in regard to the incident of 11/8/13. The QIDP indicated he lived close by the group home and went to the group home to assist staff #3 to get client C up off of the floor. When asked what happened, the QIDP stated "I think the sling was the</p>						

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W000189	<p>wrong size or something. She [staff #3] might have used the wrong one. It's on the report." When asked was there an investigation conducted, the QIDP stated, "No, I was here right after it happened and she [client C] wasn't hurt." Why would there need to be an investigation?"</p> <p>Interview with the facility administrator on 4/1/14 at 2 PM indicated all allegations of neglect and injuries of unknown origin were to be investigated.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 2 sample clients (B), the facility failed to ensure the facility staff were trained/retrained to recognize and report neglect immediately to the administrator.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 4/2/14 at 1 PM. The facility records indicated a BDDS (Bureau of Developmental Disabilities</p>	W000189	All AWS staff and supervisors at this AWS group home and AWS day program will receive training regarding the definition of abuse, neglect and, injuries of unknown origin, as well as the appropriate steps to take when reporting and investigating. This training will be competency based to ensure all staff are able to demonstrate an understanding of the training content. The AWS Director will ensure that all training is completed and documented. Addendum: The AWS Director	05/11/2014			

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	<p>Services) report dated 7/31/13.</p> <p>The report indicated "[Name of two clients and client B] attend an AWS Day Service Program in [name of city and town.] On 7-30-13 at 12:40 pm the staff at Day Services that was assigned to these clients [Day Program (DP) staff #3] was seen sleeping sitting at a table in the room with the clients. Day Service staff reported this incident to Day Service Program Manager and [DP staff #3] was suspended from work on 7/30/13 until investigation is completed." The report indicated date of knowledge of the allegation was 7/31/13.</p> <p>The investigative report dated 8/2/13 indicated "Two AWS employees, [DP staff #1 and DP staff #2] reported that they witnessed [DP staff #3] sleeping while she [DP staff #3] was supposed to be working with 3 AWS clients at the Day Program. [DP staff #1], the Activity Coordinator, did not immediately wake [DP staff #3] or suspend her after witnessing that she was sleeping. [DP staff #1] will receive retraining regarding the appropriate process to follow in a similar occurrence."</p> <p>The retraining of staff in regard to the allegations of neglect of 7/30/13 was requested. The QIDP (Qualified</p>		will review all incident reports to insure that appropriate reporting and investigation procedure is completed.				

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	<p>Intellectual Disabilities Professional) provided a "Record of Training" dated 8/21/13 for the QIDP, DP staff #6 and the Residential Manager (RM). The training indicated "If an employee is witnessed to be sleeping on the job, they should be sent home immediately and suspended until an investigation is completed. When an employee is sleeping while they are supposed to be working with clients, it is considered neglect. Do not let the staff continue to sleep, but address the issue immediately. There should be no discussion with Direct Support Employees regarding the performance of other staff. If a DSP (Direct Support Professional) states a concern or issue with the performance of another DSP, take notes and ask them to document the concern or issue. Do not make comments about the possible consequences or any personal feelings you may have about the action or individual. There should be no discussion or staff discipline issues with employees who are not directly involved in a supervisory capacity."</p> <p>The facility records indicated all facility staff were not trained/retrained in regard to the appropriate action to take when a staff is found sleeping and/or retrained to identify and report neglect.</p> <p>During interview with the QIDP on</p>			

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	<p>4/3/14 at 3 PM, the QIDP stated he was "in charge" of the Day Program. The QIDP indicated a staff sleeping while on duty was considered neglect. The QIDP indicated he had completed the BDDS report and the report indicated date of knowledge of the incident was 7/31/13. The QIDP stated "I can't remember who reported the incident or when it was reported." The QIDP stated DP staff #1 was the supervisor at the DP at the time of the incident and DP staff #1 was "supposed to be" retrained in regard to staff sleeping while on the job. The QIDP stated "I don't know where [DP staff #1's] documentation of training is." The QIDP indicated all facility staff and DP staff were not trained/or retrained in what to do when a co-worker was found sleeping or in regard to neglect after the incident of 7/30/13 with DP staff #3.</p> <p>During interview with DP staff #1 on 4/4/14 at 10:45 AM, DP staff #1 indicated another staff had seen DP staff #3 sleeping as well as herself. DP staff #1 indicated she tapped DP staff #3 on the shoulder and told her, "You need to wake up." DP staff #1 indicated DP staff #3 woke up, began moving around and went outside to smoke a cigarette. DP staff #1 indicated she did not immediately report DP staff #3 sleeping while at work but had reported it to the RM sometime later.</p>			

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W000210	<p>DP staff #1 indicated she could not remember when she reported it. DP staff #1 indicated no additional training was provided to the staff in regard to staff sleeping at work and/or neglect.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview for 1 of 2 sample clients (B) and 1 additional client (C), the facility failed to ensure client B was assessed for appropriate fitting, support and alignment of his wheel chair and to ensure clients B's and C's mechanical body slings were assessed for proper fit.</p> <p>Findings include:</p> <p>Observations were conducted at the facility group home on 4/1/14 between 4 PM and 7 PM and on 4/2/14 between 5:30 AM and 8 AM. During both observation periods, client B sat leaning to his right side while in his wheel chair.</p>	W000210	<p>All clients at this group home will have a wheelchair assessment completed by May 11, 2014 and all recommendations will be implemented. A reassessment will be completed and documented annually for each client.</p> <p>The AWS QDDP will ensure that this occurs and will report to the IDT at each quarterly meeting and annual meeting regarding current wheelchair assessment schedules, recommendations, and updates.</p>	05/11/2014	

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	<p>On 4/2/14 at 6:10 AM DCS (Direct Care Staff) #3 and #4 transferred client C from her bed to her wheelchair with the use of a mechanical lift. The sling that was used for client C did not provide client C support for her head/neck while in the sling and being transferred. Client C was able to hold her head up for a short period during the transfer but then would let her head fall back, hyperextending her head backwards without support. At 6:10 AM DSP #4 stated, "This sling is pretty new. The other one was bigger and supported her head. I don't know why we are using this one." At 6:30 AM DCS #3 and #4 transferred client B from his bed to his wheelchair with the use of a mechanical lift. The sling that was used for client B did not provide client B support for his head/neck while in the sling and while being transferred. Client B utilized a tilt in space wheelchair with a head rest for mobility and required DCS assistance for all repositioning and ADLS (Adult Daily Living Skills). DCS #4 indicated client B's body sling for the mechanical lift was left at the hospital during a recent visit and had not been returned to client B. DCS #4 stated client B's current sling had come from the day service program "a few weeks ago" and was "too small" for client B.</p> <p>Client B's record was reviewed on 4/3/14</p>				

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	<p>at 12 PM. Client B's record indicated diagnoses of, but not limited to, Seizure Disorder, Dysphagia (difficulty swallowing), Spinal Stenosis (an abnormal narrowing of the spinal canal), Constipation, Megacolon (an abnormal enlargement of the colon), Cardiomegaly (enlarged heart), CHF (Congestive Heart Failure), Urinary retention and Aerophagia (swallowing of air). Client B's record indicated client B required DCS assistance for all ADLS and needs and utilized a tilt in space wheelchair with a head rest, a lap tray and foot rests with ankle straps. Client B's record indicated no seating/mobility and/or wheelchair assessment to ensure proper fit, support and alignment while in the wheelchair. Client B's record indicated client B utilized a mechanical sling for all transfers. Client B's record indicated no assessment for the proper size and fit of the mechanical sling.</p> <p>Client C's record was reviewed on 4/3/14 at 12 PM. Client C's record indicated diagnoses of, but not limited to, Dysphagia, Quadriplegic, Spasticity and Constipation. Client C's record indicated client C utilized a wheelchair for mobility and the DCS utilized a mechanical lift to transfer client C. Client C's record indicated no assessment for the proper size and fit of the mechanical sling.</p>			

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W000225	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 1 PM stated client B had not had a wheelchair assessment to determine proper fit, support and alignment for "at least two years." The QIDP stated "I don't remember when he (client B) had his last assessment. I can't find it." The QIDP stated he "he did not know" if clients B and C had an assessment in regard to the slings that were used to transfer them.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 1 of 2 sample clients (A), the facility failed to assess client A's work skills and future employment.</p> <p>Findings include:</p> <p>Observations were conducted at the facility group home on 4/1/14 between 4 PM and 7 PM and on 4/2/14 between 5:30 AM and 8 AM and at the facility owned day program on 4/4/14 between 10:30 AM and 11:30 AM. Client A was a</p>	W000225	The client identified will have avocational assessment completed by May 11, 2014. The AWS QDDP will ensure that all clients in the group home have an annual vocational assessment completed, and will report to the IDT at each quarterly and annual meeting regarding the results of the annual assessment and all follow up plans related to it.	05/11/2014

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W000331	<p>pleasant and verbal individual that utilized a wheelchair for mobility and was able to use his right arm to maneuver and move the wheel chair on his own. Client A had no movement of his left arm, but would use his right hand to reposition his left arm.</p> <p>Client A's record was reviewed on 4/3/14 at 9 AM. Client A's record indicated client A was admitted to the facility on 10/22/13. Client A's record indicated no vocational assessment.</p> <p>Interview with client A on 4/4/14 at 11 AM indicated he had worked prior to his admission to AWS. Client A indicated he would like the opportunity to work and to make money.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 1 PM indicated client A had not had a vocational assessment and had not been assessed for work skills and/or future employment opportunities since his admission to the facility.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>						

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	<p>services in accordance with their needs.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 3 additional clients (C, D and E), the facility nursing services failed to ensure:</p> <p>__ Staff checked for proper placement prior to giving medications, feedings and or fluids via the G-tube for client C.</p> <p>__ Client B's order to give medications whole was addressed with client B's physician and the speech therapist.</p> <p>__ The MARs (Medication Administration Records) were monitored and all medications on the MAR specified the dosage and reason given for clients A, B and E.</p> <p>__ All duplicate PRN medication orders were clarified with the clients' physician for clients A and B.</p> <p>__ Staff followed the medication instructions on the medication label from the pharmacist for clients B and D.</p> <p>__ Staff gave the medications as ordered by the physician for client C.</p> <p>__ Staff conducted a triple check of medications and reported all discrepancies of the MAR to nursing for client E.</p> <p>__ Staff documented the reason for giving a PRN medication and a follow up of how the client responded to the PRN medication for client B.</p> <p>__ To ensure nursing services addressed</p>	W000331	<p>All staff at this AWS group home will receive retraining regarding appropriate medication pass protocol and tube feeding procedures from the AWS Nurse. The AWS Nurse will ensure staff are compliant in these areas by completing random med pass and tube feeding observations with the staff on a weekly basis for the next 6months.</p> <p>Addendum: The AWS Nurse will complete random bi-weekly med pass and tube feeding observations for 3 months, and then will complete weekly observations on a permanent ongoing basis. Second Addendum: The AWS Nurse will observe and complete a medication administration skills checkoff with the staff involved in the errors identified during the survey to ensure they are able to demonstrate competency. If competency is not demonstrated during the checkoff, the employee will not be permitted to pass medication until they retake Core A medication training and are able to demonstrate competency by successfully completing the course.</p>	05/11/2014

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	<p>the dietary recommendations of the dietician with the physician for client A.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 4/1/14 between 3:45 PM and 7 PM and on 4/2/14 between 5:30 AM and 8:40 AM.</p> <p>__At 5:15 PM on 4/1/14 DCS (Direct Care Staff) #2 provided client C with her evening G-tube feeding. DCS #2 inserted a 14 french straight catheter into client C's abdominal stoma. DCS #2 checked for residual stomach contents by suctioning with a syringe and obtained no residual. DCS #2 then proceeded to deliver client C's tube feeding. DCS #2 did not check the placement of the G-tube by listening for stomach sounds with a stethoscope.</p> <p>__At 7:35 AM on 4/2/14 DCS #4 provided client C with her morning G-tube feeding. DCS #4 inserted a 14 french straight catheter into client C's abdominal stoma. DCS #4 checked for residual stomach contents by suctioning with a syringe and obtained no residual. DCS #4 then proceeded to deliver client C's tube feeding. DCS #4 did not check the placement of the G-tube by listening for stomach sounds with a stethoscope.</p> <p>Review of client C's April 2014</p>			

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	<p>physician's orders on 4/2/14 at 9 AM indicated to check client C's tube placement prior to feedings.</p> <p>During interview with the RN on 4/3/14 at 3 PM, the RN was asked how the DCS were to check for proper placement of the G-tube when giving client C her feedings and/or medications. The RN indicated the DCS were to insert the catheter and listen for stomach sounds with a stethoscope prior to administering the feeding and/or medications.</p> <p>2. Observations were conducted at the group home on 4/2/14 between 5:30 AM and 8:45 AM. At 8:10 AM client B received the following medications whole (not crushed) in thickened water and fed to him on a spoon by DCS #3.</p> <p>Baclofen (a muscle relaxer) 10 mg (milligrams)</p> <p>Diazepam 5 mg for anxiety</p> <p>Ferrex 150 mg and Thera-M for dietary supplements</p> <p>Lamictal 400 mg and Phenobarbital 64.8 mg for seizures</p> <p>Claritin 10 mg for allergies</p> <p>Prilosec 40 mg to reduce acid indigestion</p> <p>Senna 17.2 mg for constipation</p> <p>Simvastatin 20 mg for cholesterol reduction</p> <p>Tamsulosin HCL .4 mg to assist urination</p> <p>Amoxicillin 125 mg (an antibiotic)</p>						

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	<p>The facility's reportable and investigative records were reviewed on 4/2/14 at 1 PM.</p> <p>__The BDDS report dated 11/30/13 indicated "On 11/29/13 after supper [client B] was coughing and lethargic (drowsy and sluggish)." Staff notified the nurse, the nurse came to the home and assessed client B. Client B was sent to ER and kept for overnight observations.</p> <p>__The BDDS report dated 2/24/14 indicated "On Feb. (February) 23, 2014 at the evening meal staff gave [client B] fluids before starting to feed him. He [client B] began to have a gurgling sound in his throat and his color was bad. Staff called RN and were instructed to do oral suctioning. Staff called RN and said that seemed to help some and color looked better. RN had staff give routine Albuterol (bronchodilator) treatment. O2 (oxygen) saturation before and after treatment was 93%. Staff called RN back and said that client was now really sleepy. RN instructed staff to take [client B] to be seen at the Urgent Care. While at Urgent Care client O2 saturation dropped to 85% and would not come back up. Urgent Care applied O2 and client was taken to ER for treatment...."</p> <p>__The BDDS report dated 3/30/14 indicated "[Client B's] diet is pureed food with thickened fluids. On 3/30/14 while [client B] was eating his lunch, his face</p>						

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	<p>became red and he was making gurgling sounds. Staff called the nurse and [client B's] face was turning purple and was told to call 911. The ambulance came to the group home and [client B] was breathing normal." Client B was taken to the hospital ER and diagnosed with pneumonia where he was treated and released to return to the group home.</p> <p>Review of the BDDS report dated 4/3/14 that was emailed to this surveyor from the QIDP on 4/9/14 at 1 PM indicated "Nurse was called by DSP (Direct Support Professional) at group home that [client B] had audible lung sounds. Nurse called Day Services where [client B] was at. Staff at Day Services said that [client B] was making audible lung sounds. Nurse went to Day Services and assessed that [client B] needed to be seen at [name of hospital] for evaluation. [Client B] was assessed by physician at ER.... [Client B] had been seen on 3/31/14 and was diagnosed with pneumonia and treated with antibiotics. [Client B] was admitted to hospital for IV (intravenous) treatment..."</p> <p>Client B's record was reviewed on 4/3/14 at 12 PM. Client B's record indicated client B had diagnoses of, but not limited to, Dysphagia (difficulty swallowing) and a history of pneumonia. Client B's record</p>			

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	<p>indicated client B was at risk for choking. Client B's 4/2014 physician's orders indicated client B was to have a pureed diet with honey thick fluids. The orders indicated client B was to be monitored for signs and symptoms of dysphagia. The orders indicated client B could take his medications whole in food. The physician's orders indicated the original order was written 3/29/10 and had not been changed since 2010.</p> <p>Client B's 4/2014 physician's orders and 4/2014 MAR indicated:            ___ Ibuprofen 600 mg three times a day for Osteoporosis.            ___ Acetaminophen 500 mg two tablets every six hours as needed (PRN) for pain or fever.            ___ Acetaminophen 500 mg two tablets every four hours as needed.            ___ Ibuprofen 400 mg one tablets every eight hours as needed.            ___ Pataday eye drops one drop into both eyes as needed at 6-8 hour intervals.            ___ Inhale Albuterol 0.5 mg via nebulizer every four hours as needed.            ___ Q- Tussin DM Syrup give 5 ml every 4-6 hours as needed.            ___ Bacitracin ointment to head of penis as needed.            ___ Silver sulfadiazine cream to affected area twice daily as needed.</p>			

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	<p>Client B's April MAR indicated client B was given Acetaminophen 500 mg on 4/1/14 at 5:30 AM and an Albuterol breathing treatment on 4/1/14 at 7 AM and 6 PM, 4/2/14 at 6 PM and on 4/3/14 at 4:30 AM. Client B's record indicated no documentation as to why client B was given Acetaminophen or Albuterol and indicated no follow up documentation as to how client B responded to the PRNs.</p> <p>During interview with the RN on 4/3/14 at 3 PM, when asked if client B was at risk for choking and the client was getting a pureed diet with honey thickened liquids, then why were his medications not being crushed, the RN stated, "He's always taken his medications whole and has never had a problem with it." When asked if the RN had documentation of that from the physician and/or a speech therapist, the RN indicated she had not addressed the need to change client B's medications to crushed with the physician and/or the speech pathologist. The RN stated the duplication and discrepancies of client B's PRN medications "would be" addressed and clarified. The RN indicated all PRN medications were to be documented by the staff when given on the MAR, a note was to be written on the nursing notes by the staff that gave it and then a follow up notation was to be made</p>						

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	<p>on the MAR indicating how the client responded to the PRN medication. The RN stated, "They (the staff) apparently didn't do that." The RN indicated she would be retraining the staff to document PRNs given and the response to the PRN.</p> <p>3. Observations were conducted at the group home on 4/2/14 between 5:30 AM and 8:45 AM.</p> <p>___At 8:10 AM DCS #3 gave client B Flonase (for allergies) two sprays in each nostril. The pharmacy label on the box of Flonase indicated to shake gently prior to administering. DCS #3 did not shake the bottle of Flonase prior to giving to client B.</p> <p>___At 8:25 AM DCS #4 gave client A two Senexon (for constipation) 8.6/50 mg tablets. The pharmacy label on the bubble pack indicated "Give 1-2 tablets." After giving the medication to client A, DCS #4 was asked why she gave client A two tablets and not one tablet. DCS #4 stated, "I don't know. I have just always given him two."</p> <p>___At 8:35 AM DCS #3 gave client D Flonase two sprays in each nostril. The pharmacy label on the box of Flonase indicated to shake gently prior to administering. DCS #3 did not shake the bottle of Flonase prior to giving to client D.</p>			

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	<p>Client A's record was reviewed on 4/3/14 at 9 AM. Client A's 4/2014 physician's orders and 4/2014 MAR indicated client A was to have one or two Senexon 8.6/50 mg tablets daily for constipation.</p> <p>Client B's record was reviewed on 4/3/14 at 12 PM. Client B's 4/2014 MAR indicated client B was to have two sprays of Flonase in each nostril daily.</p> <p>Client D's record was reviewed on 4/2/14 at 9 AM. Client D's 4/2014 MAR indicated client d was to have two sprays of Flonase in each nostril daily.</p> <p>Interview with the RN on 4/3/14 at 3 PM indicated the staff were to follow all pharmacy directions on the medication labels and the MARs when administering the clients' medications. The RN stated client A's order for Senexon "should be" clarified with the physician and rewritten as to exact dosage the client was to get.</p> <p>4. Client E's record was reviewed on 4/2/14 at 9:30 AM. Client E's December 2013 MAR indicated client E received Lorazepam at 6 AM, 12 PM and 6 PM on 12/7/13 through 12/10/13. The MAR did not indicate the dosage of Lorazepam that was given by the DCS.</p> <p>Interview with the RN on 4/3/14 at 3 PM</p>			

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	<p>indicated client C had been taking Lorazepam (for anxiety) 0.5 mg two times a day and the order was changed to three times a day. The RN indicated when the DCS transcribed the new order onto the MAR the DCS had not included the dosage of the Lorazepam. The RN stated the staff "should have" caught it when doing the triple check. When asked who was to monitor the MARs to ensure accuracy, the RN indicated nursing services. The RN indicated she was not in the group home on a daily basis and the group home supervisor or the group home manager could also check the MARs for accuracy.</p> <p>5. Client A's record was reviewed on 4/3/14 at 9 AM. Client A's 4/2014 physician's orders indicated:            ___ Ibuprofen 600 mg three times a day for Osteoporosis.            ___ Senexon-S "give 1-2 tablets orally once a day to prevent constipation."            ___ Acetaminophen 325 mg two tablets every four hours as needed for pain or fever.            ___ Ibuprofen 200 mg two tablets every four hours as needed for pain.            ___ Regular diet with regular fluids.</p> <p>Client A's Dietary assessment of 11/4/13 indicated client A was overweight and in need of weight loss. The assessment</p>			

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	<p>indicated a recommendation for client A's diet to be changed to RCS (Reduced Concentrated Sweets), seconds only on vegetables and sugar free drinks.</p> <p>Client A's Nutrition Assessment of 2/27/14 indicated client A had had gained 14.5 lbs since his admission in October. The assessment indicated client A's height was 63 inches and weight was 185.5 pounds. The assessment indicated a recommendation for client A's diet to be changed to RCS and single servings. Client A's record indicated nursing services did not address the recommendations of the dietician on 11/4/13 and 2/27/14 with client A's physician.</p> <p>Interview with the RN on 4/3/14 at 3 PM indicated client A had gained weight since his admission. The RN indicated she had recently faxed client A's doctor of the recommendations but had not gotten a response back from the doctor. The RN stated she had been away from work for a short time and the recommendation had "apparently gotten overlooked." The RN stated the duplication of client A's PRN medications "would be" addressed and clarified. The RN indicated the physician's orders on the MAR were to indicate the exact dosage. The RN</p>			

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W000369	<p>indicated client A's order for Senexon would be addressed with client A's physician and clarified.</p> <p>This federal tag relates to complaint #IN00145859.</p> <p>9-3-6(a)</p> <p>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 for 2 of 39 doses of medication administered, the facility failed to ensure staff administered client B's and C's medications as ordered by the physician and directed by the pharmacist.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/2/14 between 5:30 AM and 8:45 AM.</p> <p>__At 7:35 AM DCS (Direct Care Staff) #4 gave client C 5 ml (milliliters) of Docusate (a stool softener). The pharmacy label on the container of</p>	W000369	<p>All staff at this AWS group home will receive retraining regarding appropriate medication pass protocol and tube feeding procedures from the AWS Nurse. The AWS Nurse will ensure staff are compliant in these areas by completing random med pass and tube feeding observations with the staff on a weekly basis for the next 6 months.</p> <p>Addendum: The AWS Nurse will complete random bi-weekly med pass and tube feeding observations for 3 months, and then will complete weekly observations on a permanent ongoing basis.</p> <p>Second Addendum: The AWS Nurse will observe and complete</p>	05/11/2014			

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	<p>Docusate liquid indicated 5 ml equaled 50 mg (milligrams) and client C was to have 300 mg/30 ml.</p> <p>__ At 7:30 AM DCS #4 fed client B his breakfast.</p> <p>__ At 8:10 AM DCS #3 gave client B Thera-M (a multi vitamin). The pharmacy label on the package of Thera-M indicated client B was to take the Thera-M on an empty stomach or one hour before or two to three hours after eating a meal.</p> <p>Review of the April 2014 MARs (Medication Administration Records) for clients B and C on 4/2/14 at 9 AM indicated:</p> <p>__ Client B was to have Thera-M every AM.</p> <p>__ Client C was to have 30 ml of Docusate every AM.</p> <p>Interview with DCS #3 on 4/2/14 at 8:15 AM indicated when giving medications, the DCS were to triple check all medications with the MAR and the pharmacy instructions on the medication containers.</p> <p>Interview with DCS #4 on 4/2/14 at 8:40 AM indicated client C was to have 30 ml of Docusate instead of 5 mg. DCS #4 stated, "I knew that, I don't know why I only gave her 5 ml."</p>		a medication administration skills checkoff with the staff involved in the errors identified during the survey to ensure they are able to demonstrate competency. If competency is not demonstrated during the checkoff, the employee will not be permitted to pass medication until they retake Core A medication training and are able to demonstrate competency by successfully completing the course.				

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W000429	<p>Interview with the RN on 4/3/14 at 3 PM indicated all medications were to be given as the physician had prescribed and without error. The RN indicated the staff were to follow all pharmacy directions on the medication label.</p> <p>This federal tag relates to complaint #IN00145859.</p> <p>9-3-6(a)</p> <p>483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. Based on observation and interview for 4 of 4 clients (clients A, B, C and D) living in the group home, the facility failed to maintain the temperature in the clients' bedrooms and bathrooms within a normal comfort range of 68 degrees F (Fahrenheit) or above.</p> <p>Findings include:</p> <p>Observations were conducted at the facility group home on 4/2/14 between 5:30 AM and 8:40 AM. The facility group home was a single level three</p>	W000429	All AWS staff and supervisors at this AWS group home will receive training regarding maintaining room temperatures within a normal comfort range. AWS supervisory staff will monitor room temperatures on an ongoing basis to ensure they are appropriate. Addendum: Normal comfort range is defined as between 70 and 80 degrees. AWS Manager, Team Leader, and QDDP will each check the room temperature during weekly visits to the home. Second Addendum: The home air temperature system has been serviced and a filter was replaced	05/11/2014			

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	<p>bedroom ranch style home with large open rooms and high ceilings. Upon entering the home at 5:30 AM, all of the bedroom doors were closed. At 6:10 AM the staff opened client C's bedroom door and prepared to get the client out of bed. The temperature in client C's bedroom was 67.6 degrees. Client C was covered with a heavy comforter. At 6:15 AM the staff entered client A's and B's bedroom. The temperature of client A's and B's bedroom was 67.2 degrees. At 6:50 AM the staff entered client D's bedroom. The temperature of client D's bedroom was 66.2 degrees. Client D stated her bedroom "was cold." The staff assisted client D out of bed and into a wheelchair. Client D was wheeled into the bathroom near the kitchen. The temperature of the bathroom was 67.5 degrees. Client D stated, "It's cold in here too."</p> <p>Interview with staff #3 on 4/2/14 at 7 AM stated she had turned the thermostat up to adjust the heat because "It feels a little chilly." Staff #3 indicated the thermostat was on 70 degrees F and she had adjusted it to 74 degrees F. Staff #3 stated "It's probably a little chilly in the bedrooms because all of the doors are shut." Staff #3 indicated it was common practice to close all of the clients' bedroom doors at night. Staff #3 indicated the doors being closed provided the clients privacy.</p>		<p>since the survey occurred and is in proper working order. All group homes will have annual furnace and air conditioning completed every year to ensure proper functioning of air temperature controls. The service records will be sent to the AWS Director for review to insure functioning level is satisfactory.</p>				

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W000436	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 1 PM indicated there was no problem with the facility heating system. The QIDP indicated the staff were to keep the bedroom doors open as much as possible to allow for air circulation. The QIDP indicated the home was to be kept at an average comfortable temperature. When asked what temperature the home was to be maintained at, the QIDP indicated 70 degrees. The QIDP indicated a temperature of 66 would be cold for the clients.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 2 sampled clients with adaptive equipment, the facility failed to ensure client B's lap tray was available and used while client B was in the wheelchair.</p>	W000436	Each client's record will be reviewed by the AWS QDDP to ensure that all listed adaptive equipment is available and in use. The AWS QDDP and Residential Managers will complete weekly observation check sheets weekly for three consecutive months to ensure that all adaptive equipment	05/11/2014

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	<p>Findings include:</p> <p>Observations were conducted at the facility group home on 4/1/14 between 4 PM and 7 PM and on 4/2/14 between 5:30 AM and 8 AM. When out of bed, client B sat in a tilt in space wheel chair with leg and head rests. During both observation periods, client B was not provided with a lap tray for his wheelchair. DCS (Direct Care Staff) #3 and #4 transferred client B from bed to wheelchair with the use of a mechanical lift. The sling that was used for client B did not provide client B any support for his head/neck while in the sling and being repositioned.</p> <p>Client B's record was reviewed on 4/3/14 at 12 PM. Client B's record indicated client B utilized a tilt in space wheelchair with a head rest, a lap tray and ankle straps with foot rests.</p> <p>During interview with DCS #4 on 4/1/14 at 6:30 PM, DCS #4 stated client B had a lap tray for his wheelchair. When asked where the lap tray was, DCS #4 stated, "We (the DCS) must have left it at the day program again." DCS #4 indicated client B used his lap tray whenever he was in his wheel chair. DCS #4 indicated client B's body sling was left at the hospital during a recent visit and was not</p>		<p>is available and in use. Addendum: The AWS QDDP and Residential Manager will permanently complete weekly observation check sheets to ensure all adaptive equipment is available and in use.</p>				

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W009999	<p>returned to client B. DCS #4 stated client B's current sling had come from the day service program "a few weeks ago."</p> <p>During interview with DCS #3 on 4/2/14 at 8:10 AM indicated client B was leaning to the right while sitting in his wheel chair because he did not have his lap tray on.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 4/3/14 at 1 PM indicated client B was to use his lap tray whenever the client was up and in his wheelchair. The QIDP indicated the clients were measured for their own slings to ensure proper fit and support. The QIDP indicated the clients should be provided their own slings when using the mechanical lifts.</p> <p>9-3-7(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2 Resident protections</p>	W009999	<p>A third reference will be completed for the identified staff. All group home staff will have three complete references completed during the hiring process. The AWS Human Resources Recruiter will ensure this occurs, and the AWS Human Resources Director will</p>	05/11/2014			

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	<p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum,... three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>Based on record review and interview, for 1 of 3 staff persons reviewed (staff #4), the facility failed to ensure the references provided for staff #4 included more than verification of employment dates by the employee's previous employer.</p> <p>Findings include:</p> <p>Review of the personnel records with the HR (Human Resources) Recruiter on 4/1/14 at 1:30 PM indicated staff #4 was hired 7/15/13. Staff #4's file indicated 3 references, 1 from a long time acquaintance, 1 from a previous co-worker and 1 from a previous employer. The reference from the previous employer indicated only verification of dates of employment.</p> <p>Interview with the HR Recruiter on</p>		ensure that periodic employee file audits occur to monitor compliance.				

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	4/1/14 at 1:35 PM indicated there were 3 references for staff #4. The HR Recruiter indicated one of the three references for staff #4 indicated dates of former employment only.  9-3-2(c)(3)				