

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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 annual recertification and state licensure survey.</p> <p>Dates of Survey: August 13, 14, 16 and 23, 2013.</p> <p>Facility Number: 000904 Provider Number: 15G390 AIMS Number: 100233320</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/3/13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's governing body failed to exercise general policy and operating direction over the facility:</p> <p>__ To ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 were not restricted from the sharps and client #4 was not restricted from her clothing.</p> <p>__ To ensure the facility implemented and/or developed its written policy and procedures to ensure all injuries of unknown origin were immediately reported to the administrator and thoroughly investigated.</p> <p>__ To ensure a full and complete accounting of client #1's and #4's funds and expenditures.</p> <p>__ To ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' treatment programs.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the clients' rights in regard to restricting clients #1, #2, #3, #4, #5, #6, #7 and #8 from access</p>	W000104	<p>All staff will receive retraining on the restrictions including the improper implementation of restrictions which are not included in the clients plan or approved by the client, their representative or the Human Rights Committee. The HRC approved the intermittent restrictions for client #1 as part of the Behavior Support Plan and the staff will receive additional training on how and when to implement those restrictions. The plan will include training to allow client #1 the opportunity to develop replacement skills so that access may be earned back once safety is established. The QDDP/BC will provide an assessment to ensure that there is no reason to restrict other individual's access and will develop a plan to reintroduce them into the environment during that assessment period. Client #2 will also be assessed to determine a better plan of action for the storage of her clothing. The QDDP will assess and determine if there is a need for restricting access to dirty clothes for client #2. If there is a need, a plan will be put into place and approved through the HRC. This plan will not include any intervention which does not promote client privacy or without</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>to the sharps and restricting client #4 from free access to her clothing. Please see W125.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility maintained a complete accounting of client #1's and #4's funds and expenditures. Please see W140.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented/developed its policy and procedures to ensure all injuries of unknown origin were immediately reported to the administrator and investigated. Please see W149.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all injuries of unknown origin were reported immediately to the administrator for clients #2 and #4. Please see W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure all injuries of unknown origin were investigated for clients #2 and #4. Please see W154.</p> <p>6. The governing body failed to exercise</p>		<p>a plan to teach replacement behaviors to reinstate that right. The QDDP and Group Home Manger will do unannounced home visits at least weekly to ensure that this training has been effective and to ensure compliance. These home visits will be documented on a Home Visit Form where findings will be documented. The GHM and TL will receive retraining on the AWS financial management policy and the responsibility to ensure that all client accounts balance. Financials will be audited monthly by the compliance department but should be balanced in the home at the end of the month. Staff will also receive retraining on obtaining receipts and what to do when a receipt is not available for a purchase or when consumers keep money on their person. The director will ensure that this training has been effective by balancing the client cash on hand accounts monthly before sent to compliance. The director will initial on the ledger to document her audit and will conduct and investigation if the money is not accounted for. The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of internal injury reports to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>general policy and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' treatment programs in regard to clients #1, #2, 3, #4, #5, #6, #7 and #8. Please see W159.</p> <p>9-3-1(a)</p>		<p>communicate possible injuries. Training will also be provided to the QDDP, Nurse and house manager to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The director will sign off on the retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures. An annual CFA will be completed for each consumer. Based on the CFA, objectives will be developed outlining the areas of necessary practice. These objectives will be accompanied by a methodology sheet outlining step by step how staff are to provide guidance and training in the specific area. Staff will be trained on all consumer objectives including the specific objective, how to document, how many prompts to give, and the frequency of the objective. Objectives will be revised annually or as needed due to consumer need. The new QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in the home and being implemented</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
			appropriately. This will be documented on a home visit form.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients' rights in regard to restricting the clients from access to the sharps and restricting client #4 from free access to her clothing.</p> <p>Findings include:</p> <p>1. Review of the facility's reportable records from August 2012 to August 2013 on 8/13/13 at 11:25 AM indicated no incidents regarding improper use of sharps for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Observations were conducted at the group home on 8/13/13 between 3:30 PM and 6:15 PM. The sharp knives were in a plastic container in a kitchen cabinet above the refrigerator. The cabinet was out of reach for clients #3, #6 and #7.</p> <p>Client #1's record was reviewed on 8/14/13 at 12 PM. Client #4's revised BSP</p>	W000125	All staff will receive retraining on the restrictions including the improper implementation of restrictions which are not included in the clients plan or approved by the client, their representative or the Human Rights Committee. The HRC approved the intermittent restrictions for client #1 as part of the Behavior Support Plan and the staff will receive additional training on how and when to implement those restrictions. The plan will include training to allow client #1 the opportunity to develop replacement skills so that access may be earned back once safety is established. The QDDP/BC will provide an assessment to ensure that there is no reason to restrict other individual's access and will develop a plan to reintroduce them into the environment during that assessment period. Client #2 will also be assessed to determine a better plan of action for the storage of her clothing. The QDDP will assess and determine if there is a need for restricting access to dirty clothes for client #2. If there is a need, a plan will be put into place and	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>(Behavior Support Plan) of 11/20/12 indicated client #4 had a history of self harm using sharp objects. The BSP indicated "If [client #1] makes specific threats to hurt herself using household items such as 'I'm going to stab myself with scissors' or 'I'm going to get a kitchen knife and...' or actually does self-injure then staff must contact QMRP (QIDP - Qualified Intellectual Disabilities Professional), nursing, and/or behavior consultant immediately. Instructions will be given by one of these individuals on whether sharps should be locked up and if so what types. Staff needs to get permission from one of these individuals before sharps can be removed. These precautions will remain in place for a maximum of 24 hours unless the IDT (Interdisciplinary Team) team has met and has determined there is still a risk...."</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. Client #2's record indicated no need to restrict client #2 from sharp objects.</p> <p>Client #3's record was reviewed on 8/14/13 at 1 PM. Client #3's record indicated no need to restrict client #3 from sharp objects.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's record</p>		<p>approved through the HRC. This plan will not include any intervention which does not promote client privacy or without a plan to teach replacement behaviors to reinstate that right. The QDDP and Group Home Manger will do unannounced home visits at least weekly for the period of 3 months and then at least monthly to ensure that this training has been effective and to ensure compliance. These home visits will be documented on a Home Visit Form where findings will be documented.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>indicated no need to restrict client #4 from sharp objects.</p> <p>Interview with staff #1 on 8/13/13 at 4:45 PM stated the sharps (knives and scissors) were placed above the refrigerator "about 2 or 3 months ago" because some of the clients were using scissors to cut paper and the staff thought it was safer to put them "out of reach." Staff #1 stated "They (clients #1, #2, #3, #4, #5, #6, #7 and #8) can get them if they want to." When asked if clients #1, #2, #3, #4, #5, #6, #7 and #8 were able to reach the knives independently, staff #1 stated, "No, not all of them." Staff #1 indicated clients #2, #3, #5, #6, #7 and #8 would need staff assistance. Staff #1 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 had to ask the staff for the knives and/or scissors when they wanted to use them.</p> <p>Interview with client #3 on 8/14/13 at 7:30 AM indicated she had to ask the staff for the use of scissors and/or a knife if she wanted to use them.</p> <p>Interview with the QIDP on 8/16/13 at 11 AM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 were not restricted from the sharps in the group home. The QIDP stated the facility's Human Rights Committee, "to my knowledge hasn't approved a restriction of sharps" for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>clients #2, #3, #4, #5, #6, #7 and #8. The QIDP indicated he was aware the sharps were being stored above the refrigerator, but did not view that as a restriction as the clients could still use the sharps upon asking. The QIDP indicated client #1's BSP indicated the sharps would be locked if client #1 began making threats of self harm and/or harm to others.</p> <p>2. Observations were conducted at the group home on 8/13/13 between 5:45 AM and 8:55 AM. At 6:35 AM, wearing a bra and underwear, client #4 entered the staff office. Client #4 walked over to a clothes hamper in the corner of the office, took something out of the hamper and walked out of the room. After a few minutes, client #4, wearing no clothing, returned to the staff office from her bedroom/bathroom area and placed a pair of underwear into the clothes hamper and walked out of the room. Client #4's name was written on the laundry hamper.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's record indicated no need to restrict client #4 from her clothing.</p> <p>Interview with staff #6 on 8/14/13 at 6:45 AM stated she did not know why client #4's clothes hamper was in the staff office, "It has just always been in here."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>Interview with the QIDP on 8/16/13 at 11 AM indicated he did not know why client #4's laundry hamper was in the staff office. The QIDP stated, "I think it's just always been there." The QIDP indicated client #4's ISP and/or BSP did not include a restriction of clothing and/or a need to have client #4's laundry hamper stored in the staff office.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
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 interview and record review for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure a full and complete accounting of the clients' funds and expenditures.</p> <p>Findings include:</p> <p>Client #1's and #4's COH (Cash On Hand) ledgers for August 2013 were reviewed 8/14/13 at 11 AM with the GHM (Group Home Manager).</p> <p>Client #1's COH ledger indicated the client should have \$38.90. The client had \$36.90 in her money pouch, a difference of \$2.00.</p> <p>Client #4's COH ledger indicated the client should have \$43.27. The client had \$42.87 in her money pouch, a difference of 40 cents.</p> <p>Interview with the GHM on 8/14/13 at 11:15 AM indicated client #1's and #4's COH ledgers should match the amount in the clients' money pouches without discrepancy.</p>	W000140	<p>The GHM and TL will receive retraining on the AWS financial management policy and the responsibility to ensure that all client accounts balance. Financials will be audited monthly by the compliance department but should be balanced in the home at the end of the month. Staff will also receive retraining on obtaining receipts and what to do when a receipt is not available for a purchase or when consumers keep money on their person. The director will ensure that this training has been effective by balancing the client cash on hand accounts monthly before sent to compliance. The director will initial on the ledger to document her audit and will conduct and investigation if the money is not accounted for.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
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 2 of 4 sample clients (#2 and #4), the facility failed to develop/implement its policy and procedures to ensure all injuries of unknown origin were reported immediately to the administrator and were thoroughly investigated.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. ___ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN (Licensed Practical Nurse) on 4/9/13 indicated "health care concern rec'd (received) regarding quarter sized purple/green bruise to R (right) buttock." The note did not indicate the origin of the bruise. ___ Client #2's Health Issues Note of 4/12/13 from the staff indicated "Staff found nickel sized bruise on [client #2's] pubic area. Reported this to [name of LPN]." The note did not indicate the origin of the bruise. Client #2's Monthly Health Review for April 2013 nursing notes indicated no notes from the facility LPN in regard to the Health Issues Note of 4/12/13.</p>	W000149	The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of internal injury reports to communicate possible injuries. Training will also be provided to the QDDP, Nurse and GHM to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The Director will sign off on the retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures.	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>__ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/21/13 indicated "bruise." The note did not indicate the size, location and/or the origin of the bruise.</p> <p>__ Client #2's Skin Integrity Check Sheet for Chronic Condition for August 2013 indicated on 8/9/13 the staff noted a bruise on client #2's abdomen. The sheet did not indicate the origin of the bruise.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM.</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for February 2013 from the LPN on 2/19/13 indicated "Rec'd (received) health care concern written 2/18/13 at 8:30 pm by [name of staff] regarding [client #4's] right foot. Stating, 'right foot has sores in between toes and some of her foot is reddish purple across the whole foot, she also seems to be limping some too.' Upon assessment, Rt top of foot at base of great 2nd and 3rd toes marked with deep purple bruising. Notable swelling and discoloration continues up to portion of foot. [Client #4] jerks away when area touched. PCP (Primary Care Physician) appt (appointment) made for 2/20/13.... [Name of QIDP (Qualified Intellectual Disabilities Professional)] notified via cell of injury to Rt Foot (sic)." Client #4's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>Residential Monthly Report written by the QIDP on 3/20/13 indicated on 2/20/13 client #4 was seen for "injury to rt. Foot (sic). Xray (sic) negative for fx (fracture) or dislocation...."</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/10/13 indicated "small scratch reported left collar bone area. Scratch has the appearance of superficial finger nail scratch." The review did not indicate the origin of the scratch.</p> <p>__ Client #4's Health Care/Mental Status Concern Form dated 4/30/13 indicated "While [client #4] was bathing, I [staff] observed a purplish bruise on the inside of her R (right) knee, it is about 1 1/2 - 2" (inches) in diameter. Under her arms was (sic) also red." The form indicated no origin of client #4's injuries.</p> <p>The facility's reportable and investigative records for August 2012 through August 13, 2013 were reviewed on 8/13/13 at 11:25 AM. The facility records indicated no investigations for client #2 in regard to injuries of unknown origin reported on 4/9/13, 4/12/13, 4/21/13 and/or 8/9/13. The facility records indicated no investigations for client #4 in regard to injuries of unknown origin reported on 2/18/13, 4/10/13 and 4/30/13.</p> <p>During interview with the QIDP and the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>facility LPN on 8/16/13 at 11 AM, the QIDP indicated the RD (Regional Director) was the administrator of the facility. The QIDP stated he followed the AWS/BDDS (Bureau of Developmental Disabilities Services) reporting policy which indicated unknown injuries were any injury of unknown source that was 3 inches or larger in size and was "indicative of abuse." The QIDP indicated unknown injuries were to be reported to the administrator within 24 hours of the time of discovery of the injury. The LPN stated, "I don't do investigations." The LPN indicated she reported issues that would need an investigation to the QIDP and then the QIDP would investigate. The QIDP stated he was responsible for conducting investigations of injuries of unknown origin. The QIDP stated the injuries of unknown origin for client #2 of 4/9/13, 4/12/13, 4/21/13 and 8/9/13 and for client #4 of 2/18/13, 4/10/13 and 4/30/13 were not reported to the administrator and/or investigated because the injuries were not larger than 3 inches in size and/or were not "indicative" of abuse."</p> <p>Review of the revised Incident Reporting and Investigation Policy of 6/13/13 on 8/13/13 at 1 PM indicated "Investigations will take place for the following incidents including, but not limited to: ...unknown</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>injury...." The policy indicated "Incidents that must be reported to the Division of Disability and Rehabilitative Services (DDRS).... 13. Any injury to an individual when the cause is unknown and the injury could be indicative of abuse, neglect or exploitation.... 14d. A significant injury to an individual that includes, but is not limited to: bruises or contusions larger than three inches in any direction, or a pattern of bruises or contusions regardless of size...." The policy did not include injuries of unknown origin were to be reported immediately to the administrator.</p> <p>Review of the facility revised 3/2011 Indiana Abuse and Neglect policy on 8/13/13 at 1 PM indicated "If any staff witness, observed, or suspect abuse, neglect or exploitation of an individual, they are to report this immediately to their supervisor and the AWS Program Director. The supervisor/director is responsible for reporting the incident to all appropriate entities.... 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.... Failure to report an abuse is also considered neglectful."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on interview and record review for 7 of 8 injuries of unknown origin for clients #2 and #4, the facility failed to ensure all injuries of unknown origin were reported immediately to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. __ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN (Licensed Practical Nurse) on 4/9/13 indicated "health care concern rec'd (received) regarding quarter sized purple/green bruise to R (right) buttock." The note did not indicate the origin of the bruise. __ Client #2's Health Issues Note of 4/12/13 from the staff indicated "Staff found nickel sized bruise on [client #2's] pubic area. Reported this to [name of LPN]." The note did not indicate the origin of the bruise. Client #2's Monthly Health Review for April 2013 nursing</p>	W000153	The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of internal injury reports to communicate possible injuries. Training will also be provided to the QDDP, Nurse and house manager to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The director will sign off on the retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures.	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>notes indicated no notes from the facility LPN in regard to the Health Issues Note of 4/12/13 to indicate the origin of the bruise.</p> <p>__ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/21/13 indicated "bruise." The note did not indicate the size, location and/or the origin of the bruise.</p> <p>__ Client #2's Skin Integrity Check Sheet for Chronic Condition for August 2013 indicated on 8/9/13 the staff noted a bruise on client #2's abdomen. The sheet did not indicate the origin of the bruise.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM.</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for February 2013 from the LPN on 2/19/13 indicated "Rec'd (received) health care concern written 2/18/13 at 8:30 pm by [name of staff] regarding [client #4's] right foot. Stating, 'right foot has sores in between toes and some of her foot is reddish purple across the whole foot, she also seems to be limping some too.' Upon assessment, Rt top of foot at base of great 2nd and 3rd toes marked with deep purple bruising. Notable swelling and discoloration continues up to portion of foot. [Client #4] jerks away when area touched. PCP (Primary Care Physician)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>appt (appointment) made for 2/20/13.... [Name of QIDP (Qualified Intellectual Disabilities Professional)] notified via cell of injury to Rt Foot (sic)." Client #4's Residential Monthly Report written by the QIDP on 3/20/13 indicated on 2/20/13 client #4 was seen for "injury to rt. Foot (sic). Xray (sic) negative for fx (fracture) or dislocation...."</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/10/13 indicated "small scratch reported left collar bone area. Scratch has the appearance of superficial finger nail scratch." The review did not indicate the origin of the scratch.</p> <p>__ Client #4's Health Care/Mental Status Concern Form dated 4/30/13 indicated "While [client #4] was bathing, I [staff] observed a purplish bruise on the inside of her R (right) knee, it is about 1 1/2 - 2" (inches) in diameter. Under her arms was (sic) also red." The form indicated no origin of client #4's injuries.</p> <p>The facility's reportable and investigative records for July 2012 through August 13, 2013 were reviewed on 8/13/13 at 11:25 AM. The facility records did not indicate the administrator was immediately notified of the injuries of unknown origin for clients #2 and #4.</p> <p>During interview with the QIDP and the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>facility LPN on 8/16/13 at 11 AM, the QIDP indicated the RD (Regional Director) was the administrator of the facility. The QIDP stated he followed the AWS/BDDS (Bureau of Developmental Disabilities Services) reporting policy which indicated unknown injuries were any injury of unknown source that was 3 inches or larger in size and was "indicative of abuse." The QIDP indicated unknown injuries were to be reported to the administrator within 24 hours of the time of discovery of the injury. The QIDP stated the injuries of unknown origin for client #2 of 4/9/13, 4/12/13, 4/21/13 and 8/9/13 and for client #4 of 2/18/13, 4/10/13 and 4/30/13 were not reported to the administrator because they were not larger than 3 inches in size and were not "indicative" of abuse."</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
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 interview and record review for 7 of 8 injuries of unknown origin for clients #2 and #4, the facility failed to provide evidence of an investigation.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM.</p> <p>__ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN (Licensed Practical Nurse) on 4/9/13 indicated "health care concern rec'd (received) regarding quarter sized purple/green bruise to R (right) buttock." The note did not indicate the origin of the bruise.</p> <p>__ Client #2's Health Issues Note of 4/12/13 from the staff indicated "Staff found nickel sized bruise on [client #2's] pubic area. Reported this to [name of LPN]." The note did not indicate the origin of the bruise. Client #2's Monthly Health Review for April 2013 nursing notes indicated no notes from the facility LPN in regard to the Health Issues Note of 4/12/13.</p> <p>__ Client #2's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/21/13 indicated</p>	W000154	The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of internal injury reports to communicate possible injuries. Training will also be provided to the QDDP, Nurse and house manager to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The director will sign off on these retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures.	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>"bruise." The note did not indicate the size, location and/or the origin of the bruise.</p> <p>__ Client #2's Skin Integrity Check Sheet for Chronic Condition for August 2013 indicated on 8/9/13 the staff noted a bruise on client #2's abdomen. The sheet did not indicate the origin of the bruise.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM.</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for February 2013 from the LPN on 2/19/13 indicated "Rec'd (received) health care concern written 2/18/13 at 8:30 pm by [name of staff] regarding [client #4's] right foot. Stating, 'right foot has sores in between toes and some of her foot is reddish purple across the whole foot, she also seems to be limping some too.' Upon assessment, Rt top of foot at base of great 2nd and 3rd toes marked with deep purple bruising. Notable swelling and discoloration continues up to portion of foot. [Client #4] jerks away when area touched. PCP (Primary Care Physician) appt (appointment) made for 2/20/13.... [Name of QIDP (Qualified Intellectual Disabilities Professional)] notified via cell of injury to Rt Foot (sic)." Client #4's Residential Monthly Report written by the QIDP on 3/20/13 indicated on 2/20/13 client #4 was seen for "injury to rt. Foot</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>(sic). Xray (sic) negative for fx (fracture) or dislocation...."</p> <p>__ Client #4's Health Care Coordination Monthly Health Review for April 2013 from the LPN on 4/10/13 indicated "small scratch reported left collar bone area. Scratch has the appearance of superficial finger nail scratch." The review did not indicate the origin of the scratch.</p> <p>__ Client #4's Health Care/Mental Status Concern Form dated 4/30/13 indicated "While [client #4] was bathing, I [staff] observed a purplish bruise on the inside of her R (right) knee, it is about 1 1/2 - 2" (inches) in diameter. Under her arms was (sic) also red." The form indicated no origin of client #4's injuries.</p> <p>The facility's reportable and investigative records for July 2012 through August 13, 2013 were reviewed on 8/13/13 at 11:25 AM. The facility records indicated no investigations for client #2 in regard to injuries of unknown origin reported on 4/9/13, 4/12/13, 4/21/13 and/or 8/9/13. The facility records indicated no investigations for client #4 in regard to injuries of unknown origin reported on 2/18/13, 4/10/13 and 4/30/13.</p> <p>During interview with the QIDP and the facility LPN on 8/16/13 at 11 AM, the QIDP stated the facility followed the BDDS (Bureau of Developmental</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>Disabilities Services) policy for reporting/investigating in regard to unknown injuries and did not investigate injuries of unknown origin unless the injury was "larger than 3 inches" in size or was "indicative of abuse." The LPN stated, "I don't do investigations." The LPN indicated she reported issues that would need an investigation to the QIDP and then the QIDP would investigate. The QIDP stated he was responsible for conducting investigations of injuries of unknown origin. The QIDP indicated the injuries of unknown origin for client #2 of 4/9/13, 4/12/13, 4/21/13 and 8/9/13 were not investigated. The QIDP indicated the injuries of unknown origin for client #4 of 2/18/13, 4/10/13 and 4/30/13 were not investigated.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 4 of 4 sample clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility QIDP (Qualified Intellectual Disabilities Professional) failed to ensure:</p> <p>__ The clients were not restricted from access to the sharps.</p> <p>__ The clients' funds were maintained without error.</p> <p>__ All injuries of unknown origin were reported immediately to the administrator and investigated.</p> <p>__ The methodology for client objectives was specified in the clients' ISPs (Individualized Support Plans).</p> <p>__ The clients' identified training needs were addressed.</p> <p>__ The staff monitored client #4 around food and provided her with a mechanical soft diet.</p> <p>__ Activity schedules were developed.</p> <p>__ A plan of reduction was in place for behavior modification medications.</p> <p>__ The clients were provided medication training.</p> <p>__ The use of sedation for client #7 was reported to Bureau of Developmental Disabilities Services (BDDS).</p>	W000159	<p>All staff will receive retraining on the restrictions including the improper implementation of restrictions which are not included in the clients plan or approved by the client, their representative or the Human Rights Committee. The HRC approved the intermittent restrictions for client #1 as part of the Behavior Support Plan and the staff will receive additional training on how and when to implement those restrictions. The plan will include training to allow client #1 the opportunity to develop replacement skills so that access may be earned back once safety is established. The QDDP/BC will provide an assessment to ensure that there is no reason to restrict other individual's access and will develop a plan to reintroduce them into the environment during that assessment period. Client #2 will also be assessed to determine a better plan of action for the storage of her clothing. The QDDP will assess and determine if there is a need for restricting access to dirty clothes for client #2. If there is a need, a plan will be put into place and approved through the HRC. This plan will not include any intervention which does not</p>	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to ensure client #1's, #2's, #3's, #4's, #5's, #6's, #7's and #8's rights in regards to restricting the clients from the sharps and to ensure client #4 was not restricted from her clothing. Please see W125. 2. The QIDP failed to ensure a full and complete accounting of client #1's and #4's funds and expenditures. Please see W140. 3. The QIDP failed to ensure all injuries of unknown origin were reported immediately to the administrator and were thoroughly investigated for clients #2 and #4. Please see W149. 4. The QIDP failed to ensure all injuries of unknown origin were reported immediately to the administrator for clients #2 and #4. Please see W153. 5. The QIDP failed to ensure all injuries of unknown origin were thoroughly investigated for clients #2 and #4. Please see W154. 6. The QIDP failed to ensure the methods to be used to implement client #1's, #2's, #3's and #4's ISPs (Individual Support 		<p>promote client privacy or without a plan to teach replacement behaviors to reinstate that right. The QDDP and Group Home Manger will do unannounced home visits at least weekly to ensure that this training has been effective and to ensure compliance. These home visits will be documented on a Home Visit Form where findings will be documented. The GHM and TL will receive retraining on the AWS financial management policy and the responsibility to ensure that all client accounts balance. Financials will be audited monthly by the compliance department but should be balanced in the home at the end of the month. Staff will also receive retraining on obtaining receipts and what to do when a receipt is not available for a purchase or when consumers keep money on their person. The director will ensure that this training has been effective by balancing the client cash on hand accounts monthly before sent to compliance. The director will initial on the ledger to document her audit and will conduct and investigation if the money is not accounted for. The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>Plans) objectives were clearly specified in the clients' ISP. Please see W234.</p> <p>7. The QIDP failed to ensure the clients' ISPs addressed the clients' identified training needs in regard to client #2's and #4's toileting, bathing and dressing, client #3's dressing and client #4's privacy. Please see W242.</p> <p>8. The QIDP failed to ensure the staff followed client #4's ISP and BSP (Behavior Support Plan) in regard to client #4's dining needs, food consumption and supervision while food was being prepared. Please see W249.</p> <p>9. The QIDP failed to ensure a schedule was developed that outlined client #1's, #2's, #3's and #4's current active treatment schedule/programs. Please see W250.</p> <p>10. The QIDP failed to ensure a specific plan of reduction was in place to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target for clients #1, #3 and #4. Please see W312.</p> <p>11. The QIDP failed to develop medication objectives to provide medication training for clients #1 #2 and #4. Please see W371.</p>		<p>internal injury reports to communicate possible injuries. Training will also be provided to the QDDP, Nurse and house manager to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The director will sign off on the retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures. An annual CFA will be completed for each consumer. Based on the CFA, objectives will be developed outlining the areas of necessary practice. These objectives will be accompanied by a methodology sheet outlining step by step how staff are to provide guidance and training in the specific area. Staff will be trained on all consumer objectives including the specific objective, how to document, how many prompts to give, and the frequency of the objective. Objectives will be revised annually or as needed due to consumer need. The new QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>12. The QIDP failed to ensure the staff provided food in accordance with client #4's diet order. Please see W460.</p> <p>13. The QIDP failed to notify the BDDS within 24 hours in accordance with state law regarding the use of general anesthesia for a dental procedure for client #7. Please see W9999.</p> <p>9-3-3(a)</p>		<p>the home and being implemented appropriately. This will be documented on a home visit form. All staff will receive retraining on the restrictions including the improper implementation of restrictions which are not included in the clients plan or approved by the client, their representative or the Human Rights Committee. The HRC approved the intermittent restrictions for client #1 as part of the Behavior Support Plan and the staff will receive additional training on how and when to implement those restrictions. The plan will include training to allow client #1 the opportunity to develop replacement skills so that access may be earned back once safety is established. The QDDP/BC will provide an assessment to ensure that there is no reason to restrict other individual's access and will develop a plan to reintroduce them into the environment during that assessment period. Client #2 will also be assessed to determine a better plan of action for the storage of her clothing. The QDDP will assess and determine if there is a need for restricting access to dirty clothes for client #2. If there is a need, a plan will be put into place and approved through the HRC. This plan will not include any intervention which does not promote client privacy or without a plan to teach replacement</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
			behaviors to reinstate that right. The QDDP and Group Home Manger will do unannounced home visits at least weekly for a period of 3 months and then monthly to ensure that this training has been effective and to ensure compliance. These home visits will be documented on a Home Visit Form where findings will be documented. The GHM and TL will receive retraining on the AWS financial management policy and the responsibility to ensure that all client accounts balance. Financials will be audited monthly by the compliance department but should be balanced in the home at the end of the month. Staff will also receive retraining on obtaining receipts and what to do when a receipt is not available for a purchase or when consumers keep money on their person. The director will ensure that this training has been effective by balancing the client cash on hand accounts monthly before sent to compliance. The director will initial on the ledger to document her audit and will conduct and investigation if the money is not accounted for. The AWS Group Home Unknown Injury and the Reportable Incidents policies have been revised to provide clear instruction related to unknown injuries. All staff have received re-training on their responsibility to report injuries of unknown origin and completion of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
			<p>internal injury reports to communicate possible injuries. Training will also be provided to the QDDP, Nurse and house manager to ensure they understand their obligations to report to the administrator, participate in or conduct an investigation and internal and external reporting procedures. The director will sign off on the retraining forms. The professional staff will be retrained on the AWS Investigation Policy to ensure their understanding of proper investigation procedures. An annual CFA will be completed for each consumer. Based on the CFA, objectives will be developed outlining the areas of necessary practice. These objectives will be accompanied by a methodology sheet outlining step by step how staff are to provide guidance and training in the specific area. Staff will be trained on all consumer objectives including the specific objective, how to document, how many prompts to give, and the frequency of the objective. Objectives will be revised annually or as needed due to consumer need. The new QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
			<p>the home and being implemented appropriately. This will be documented on a home visit form. The new QDDP will be trained on ensuring client rights, monitoring client funds, reporting and investigation all injuries of unknown origin, developing objectives based on the CFA, ensuring ISP contains all necessary consumer data, ensuring active treatment schedules are developed and followed for each consumer and notifying Director and BDDS within 24 hours for all reportable incidents. Finances are completed by GHM, will be signed off on by QDDP, sent to director for review and signature, then forwarded to AWS corporate compliance for review. The QDDP will be trained by experienced AWS ADDPs according to all ISDH regulations. The QDDP is supervised by the Regional Director. A weekly professional staff conference will be held to discuss all job duties, concerns in the group home, home visits, and incident reports.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
W000234	<p>483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>Based on record review and interview for 4 of 4 sample clients (#1, #2, #3 and #4), the facility failed to specify the methods to be used to implement the clients' ISP (Individual Support Plans) objectives.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/14/13 at 12 PM. Client #1's ISP of 9/4/12 indicated client #1 had training objectives:</p> <ul style="list-style-type: none"> To clean her bedroom. To independently go to the staff when it was time for medications. To wash her hair, to participate in a leisure activity of her choice. To purchase an item in the community. To go to staff and talk about her feelings. <p>Client #1's ISP indicated no methodology sheets for the staff to reference to implement the client's objectives.</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. Client #2's ISP of 9/11/12 indicated client #2 had training objectives:</p> <ul style="list-style-type: none"> To identify a quarter. To wash her hands prior to taking 	W000234	<p>Methodology sheets should accompany all consumer objectives. These methodology sheets are created and implemented at the same time as objectives and will be present in the home before the month goals are set to begin. The QDDP will receive training by experienced AWS QDDPs to write and implement proper objectives and to include all necessary parts including methodology sheets.</p> <p>The QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure only well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in the home and being implemented appropriately. This will be documented on a home visit form.</p>	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>medications.</p> <p>To clean her bedroom.</p> <p>To wash her hands for 30 seconds.</p> <p>To play a board game.</p> <p>Client #2's ISP indicated no methodology sheets for the staff to reference to implement the client's objectives.</p> <p>Client #3's record was reviewed on 8/14/13 at 1 PM. Client #3's ISP of 9/4/12 indicated client #3 had training objectives:</p> <p>To identify a quarter.</p> <p>To communicate her feelings.</p> <p>To name 2 of her medications.</p> <p>To wash her hair for 30 seconds.</p> <p>To choose a leisure activity.</p> <p>Client #3's ISP indicated no methodology sheets for the staff to reference to implement the client's objectives.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's ISP of 9/13/12 indicated client #4 had training objectives:</p> <p>To identify a quarter.</p> <p>To regulate the hot water.</p> <p>To wash her hair for 30 seconds.</p> <p>Client #4's ISP indicated no methodology sheets for the staff to reference to implement the client's objectives.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	8/14/13 at 2 PM indicated every objective was to have a methodology sheet that explained step by step how the staff were to implement each of the clients' objectives. 9-3-4(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4), the ISP (Individual Support Plan) failed to address the clients' identified training needs in regard to:</p> <p>__ Toileting, bathing and dressing for clients #2 and #4. __ Dressing for client #3. __ Personal privacy for client #4.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/13/13 between 5:45 AM and 8:55 AM. At 6:35 AM client #8 was getting her morning medications in the staff office. Client #4 entered the staff office while client #8 was receiving her medications without knocking on the door and wearing a bra and underwear. Client #4 walked over to a clothes hamper in the corner of the office, took something out of it and walked out of the room. After a few minutes, client #4 again walked into</p>	W000242	<p>An annual CFA will be completed for each consumer. Based on the CFA, objectives will be developed outlining the areas of necessary practice. These objectives will be accompanied by a methodology sheet outlining step by step how staff are to provide guidance and training in the specific area. Staff will be trained on all consumer objectives including the specific objective, how to document, how many prompts to give, and the frequency of the objective. Objectives will be revised annually or as needed due to consumer need. The QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure only well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in the home and being implemented appropriately. This will be documented on a home visit form.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>the staff office while client #8 was still getting her medications. Client #4 did not knock and this time was naked. Client #4 walked over to the clothes hamper, placed a pair of underwear into the hamper and walked out of the room. At 6:40 AM staff #6 stated, "She does that all the time." The staff did not prompt client #4 in providing privacy for client #8 by knocking prior to opening the door and/or redirect client #4 in personal privacy.</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. Client #2's CFA (Comprehensive Functional Assessment) of 8/23/12 indicated client #2 required staff assistance to wipe after toileting, to wash her hands after toileting, to bathe and to dress in clean fitted clothing that was weather appropriate. Client #2's ISP of 9/11/12 did not include any training objectives to assist client #2 with her identified training needs in regard to toileting, bathing and dressing.</p> <p>Client #3's record was reviewed on 8/14/13 at 1 PM. Client #3's CFA (Comprehensive Functional Assessment) of 8/16/12 indicated client #3 required staff assistance to dress in clean fitted clothing that was weather appropriate. Client #3's ISP of 9/4/12 did not include any training objectives to assist client #3 with her identified training needs in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>regard to dressing.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's CFA of 8/16/12 indicated client #4 did not understand the difference between public and private. Client #4's CFA indicated client #4 required staff assistance to wipe after toileting, to bathe and to dress in clean fitted clothing that was weather appropriate. Client #4's ISP of 9/13/12 did not include any training objectives to assist client #4 with her identified training needs in regard to personal privacy, toileting, bathing and dressing.</p> <p>Interview with staff #1 on 8/14/13 at 5:45 AM indicated clients #2 and #4 required staff assistance and prompting to wipe after toileting and to bathe. Staff #1 indicated clients #2, #3 and #4 required staff supervision to ensure they were dressed appropriately for the weather and/or were dressed in clothing that was clean, fitted and in good repair.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/16/13 at 11 AM, indicated clients #2 and #4 did not have any training objectives in toileting, bathing and/or dressing. The QIDP indicated client #3 did not have any objectives to assist client #3 in dressing. The QIDP indicated client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	#4 did not understand the difference between public and private and did not have any training objectives in place to assist her with personal privacy issues. 9-3-4(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the staff followed client #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) in regards to client #4's dining needs, food consumption and supervision while food was being prepared.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/13/13 between 3:30 PM and 6:15 PM.</p> <p>__ At 4 PM client #4 assisted to place whole pieces of chicken in a baking pan to place in the oven.</p> <p>__ At 4:45 PM client #4 stood in front of the kitchen sink, with an open loaf of bread sitting on the counter to her right. Client #4 looked over her shoulder to see if anyone was watching while reaching into the bag of bread. Client #4 looked at this surveyor and withdrew her hand from the bag of bread. Client #4 then walked out into the garage where there were 2</p>	W000249	<p>Staff will be retrained on each consumer's ISP, BSP and all risk plans before working with them and at least annually there after. These trainings are documented on a client specific training form and retained by Human Resources. Staff will be trained by the QDDP on goal tracking and following ISP and BSP. Staff will be trained by the LPN on following risk plans. AWS is in the process of hiring a behavior specialist to work with this group home and staff will be trained by the onsite BS for all consumers behavior plans and how to appropriately follow and implement. The dietician will visit the home quarterly to monitor diet plans and meet with staff. The dietician visited the home in August and will be there again in November. The LPN will implement all recommendations will train staff on all recommendations given by the dietician. The dietician also attended a staff training meeting in September to offer onsite training directly to the staff. The Regional Director will sign off on</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>freezers and a refrigerator. Client #4 opened the refrigerator and freezer and stood looking at the contents.</p> <p>__At 4:50 PM this surveyor asked staff #2 if client #4 was to be in the garage by herself. Staff #2 stated, "No, why? Is she looking for food again in the garage? She steals food and eats it. It's in her plan." Staff #2 entered the garage and prompted client #4 to close the refrigerator door and to come back inside the house.</p> <p>__At 5:10 PM staff #2 took the baked chicken out of the oven and set it on top of the stove.</p> <p>__At 5:20 PM staff #2 put most of the chicken into a large bowl and set the bowl on the kitchen island countertop. As staff #1, #2 and #3 made final meal preparations and prompted all the clients to wash their hands for the evening meal, client #4 stood in front of the stove, glanced over her shoulder to see if the staff were watching her and picked up a piece of baked chicken from the baking pan on the stove and quickly placed it in her mouth and ate it. Client #4 looked around again and then took another piece of chicken, eating it. Client #4 then stepped over in front of the bowl of chicken sitting on the island countertop. Client #4 glanced around to see if anyone was watching her, took a piece of chicken out of the bowl and quickly placed it into her mouth and ate it. Client #4 repeated</p>		these record of trainings to ensure staff are comprehensively trained.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>this two more times.</p> <p>__At 5:30 PM staff #2 prompted client #4 to sit down at the table for the evening meal. Staff #2 cut up client #4's chicken and client #4 immediately began eating the chicken with her fingers. Client #4 used a toddler utensil while eating, took large bites and ate her food at a fast pace.</p> <p>__At 5:37 PM client #4 was given a slice of bread that was cut into small cubes. Client #4 ate the bread at a fast pace, placing several cubes of bread in her mouth at once.</p> <p>__At 5:45 PM client #4 was finished with her meal and sat watching the other clients eating their meal.</p> <p>__At 5:52 PM staff #2 asked client #4 if she wanted more chicken. Client #2 took 2 more pieces of chicken out of the bowl and quickly began eating them, tearing off large pieces at a time with her fingers and placing them in her mouth. The staff did not assist client #4 to cut up the extra portion of chicken.</p> <p>__At 6 PM client #4 had finished her meal, got up from the table, picked up her glass of liquid and drank it down at a fast pace. Client #6 did not eat all of her chicken and had pushed her plate aside while eating a bowl of fruit cocktail. Client #4 picked up client #6's plate, walked over to the trash can and stood. At the same time, staff #1 stated, "[Client #4] you know you can't eat off of [client #6's]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>plate." Client #4 then emptied client #6's uneaten food into the trash can and took the plate to the sink.</p> <p>__ Prior to the evening meal, the staff did not closely supervise client #4 or redirect client #4 from eating food out of the baking pan or the serving bowl with her fingers.</p> <p>__ During the evening meal, staff #1, #2, #3 and #4 sat at the dining room table with client #4 and her housemates. Staff #2 sat next to client #4. The staff did not prompt client #4 to slow her pace of eating, to take smaller bites, to put her fork down between bites, to take a drink in between bites or to cut her food into smaller pieces.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM.</p> <p>__ Client #4's ISP of 9/13/12 indicated client #4 "Has a tendency to eat very quickly, she needs reminded to slow down.... Needs HAND OVER HAND assistance to cut food into small pieces prior to eating. Staff must sit next to her when she is eating. Needs prompted to slow down...." Client #4's ISP indicated client #4 had an objective to learn table manners. The ISP indicated client #4 was to place her utensil down between each bite of food and the staff were to make sure client #4 was completely chewing her food and swallowing prior to taking</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>another bite of food.</p> <p>__ Client #4's 10/1/12 Risk Summary indicated client #4 was at risk of choking. The plan indicated "Staff will be sure that [client #4] is given a mechanical soft diet.... Staff will verbally prompts (sic) [client #4] to slow pace of eating during meals. [Client #4] will use a smaller utensil to reduce overloading of food."</p> <p>__ Client #4's revised BSP of 11/20/12 indicated client #4 had a targeted behavior of "Dangerous eating: Consuming uncooked food, eating out of the trash, putting large quantities of food into her mouth, eating out of 'community' containers." The BSP indicated client #4 had a history of consuming uncooked items or retrieving garbage from the trash to eat. "Recently she was redirected from eating food out of the sink. Staff reports [client #4] has eaten uncooked meat out of the pan on the stove and directly from the refrigerator before they could intervene. [Client #4] has a long history of attempting to eat out of the trash and has needed redirection not to do so.... [Client #4] has a tendency to cram large amounts of food into her mouth when she is eating during unscheduled at times. For example, staff has found her dipping her hand into a cottage cheese container and peanut butter jar and eating as well as consuming handfuls of crackers, cereal, and/or bread. [Client #4] will rarely leave</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>the kitchen upon returning home from the workshop during the weekdays and needs constant supervision to keep her safe...."</p> <p>The BSP indicated reactive strategies of dangerous eating to be:</p> <p>__ "OBSERVATION: Whenever [client #4] is in the kitchen staff will need to watch [client #4] closely to ensure she does not consume anything that could be potentially harmful to her. Unless [client #4] is next to a hot stove, staff should observe her from a distance of 3 to 4 feet. If she feels staff is too close she is more likely going to become aggressive. Seeing staff does not always prevent [client #4] from eating items but staff can be there in case [client #4] would become choked or need assistance."</p> <p>__ "VERBAL REDIRECT: If [client #4] is attempting to get food that is not cooked or attempting to eat food out of the trash then staff should redirect her verbally. BUT NOT PHYSICALLY. Attempting to take food out of her hands will only result in [client #4] becoming physically aggressive or shoving food into her mouth resulting in increased risk for choking. If she is eating bread or other items you can redirect her and let her know what time dinner and/or snack will be and ask her to wait but again do not attempt to take food out of her hand."</p> <p>__ "COOKING: when cooking staff need to be next to the stove at all times to help</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>block [client #4] from grabbing food. She is less likely to attempt to grab something off of the stove if a staff member is right there. This will require two staff present in the kitchen when cooking - one to assist peers with cooking and the other staff to help observe and redirect [client #4]...."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/16/13 at 11 AM indicated the staff were to supervise client #4 closely at all times to prevent client #4 from eating foods other than food provided her during snacks and/or meals. The QIDP stated the staff "should have" supervised client #4 closely and redirected her away from the garage. The QIDP indicated the staff were to follow client #4's ISP and BSP in regard to client #4's consumption of dangerous foods, cutting her food and prompting client #4 to slow her pace of eating, to take small bites, to take a drink between bites and to lay her utensil down between bites.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to develop a schedule that outlined the clients' current active treatment schedule/programs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/14/13 at 12 PM. Client #1's record indicated no active treatment schedule for client #1.</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. Client #2's record indicated no active treatment schedule for client #2.</p> <p>Client #3's record was reviewed on 8/14/13 at 1 PM. Client #3's record indicated no active treatment schedule for client #3.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's record indicated no active treatment schedule for client #4.</p> <p>Interview with the QIDP (Qualified</p>	W000250	Active treatment schedules have been created for each client. Staff will be trained to review these schedules daily to know the individual schedules of each consumer. All residents are affected and corrective action will address the needs of all clients. QDDP will be responsible for updating these schedules and placing in the homes. Team Leaders will be responsible for ensuring staff are reviewing and following these schedules. Management will review these active treatment schedules monthly when they go to the homes to assure environmental quality. Director will sign off on staff training to use and implement client active treatment schedules.	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>Intellectual Disabilities Professional) on 8/14/13 at 2 PM indicated he was unable to find an active treatment schedule for clients #1, #2, #3 and #4. The QIDP indicated he had seen active treatment schedules in the past few years, but was not sure what had happened to them and/or why the facility no longer used them.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 3 sampled clients receiving medications to control behaviors (#1, #3 and #4), the facility failed to ensure a specific plan of reduction was in place to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/14/13 at 12 PM. Client #1's 8/1/13 physician's orders indicated client #1 took the following medications for behavior modification: Wellbutrin 200 mg (milligrams) qd (every day), Divalproex (Depakote) 500 mg bid (twice a day), Seroquel 300 mg qd and Gabapentin (Neurontin) 200 mg bid. Client #1's BSP (Behavior Support Plan) of 11/20/12 indicated client #1 had targeted behaviors of refusals, verbal/nonverbal aggression, physical aggression and self-injury. Client #1's BSP indicated client #1 was taking Wellbutrin 200 mg qd, Depakote 750 mg qd and Seroquel 350 mg qd. The BSP</p>	W000312	The Behavior Clinician that was previously working at this home is no longer contracted with AWS. A temporary BC has been contracted from corporate office who will be revising BSPs to include consumer specific titration plans. AWS is currently recruiting for a permanent behavior specialist to monitor the behavior plans of this home. All residents receiving psychotropic medications are affected and corrective action will address the needs of all clients. The temporary BC is supervised by Dr. Jim Wiltz of AWS. The new behavior specialist will be mentored by Dr. Wiltz who will provide oversight and will sign off on all BSPs. BSPs will be written and revised by a BC employed by AWS. Dr. Wiltz will provide mentoring and sign off on all BSPs. The QDDP will continue to use the Quarterly Meeting Checklist which encourages the team to discuss behavior support plans, dates and titration plans. The IDT will sign off on this checklist and it will be forwarded to the Director for review and signature.	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>indicated a medication reduction plan for the Seroquel, Wellbutrin and Depakote to be "If [client #1] continues to show progress in her replacement behavior and if there is a reduction in negative behaviors, the team will consider a psychotropic medication reduction. Unless clinical contraindication exists such as ongoing significant behaviors that represent a risk to the safety or (sic) herself or others, a medication reduction should be attempted at least annually." Client #1's BSP did not indicate the targeted behaviors for which each medication was taken and did not include the use of Gabapentin and/or a plan of reduction for the Gabapentin. Client #1's BSP indicated no specific plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Client #3's record was reviewed on 8/14/13 at 1 PM. Client #3's 8/1/13 physician's orders indicated client #3 took the following medications for behavior modification: Risperdal 2 mg qd, Lamictal 200 mg qd, Trazodone 25 mg qhs (every night at bedtime) and Buspirone 5 mg bid. Client #3's BSP of 1/11/13 indicated client #3 had targeted behaviors of agitation, perceived helplessness, noncompliance, exaggerating, instigating conflict,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>depressive symptoms, property destruction and physical aggression. Client #3's BSP indicated client #3 was taking Risperdal 2 mg qd, Lamictal 200 mg qd and Trazodone 12.5 mg qhs. Client #3's BSP indicated a plan of reduction for the Risperdal, Lamictal and the Trazodone to be "If [client #3] continues to show progress in her replacement behavior objective and if there is a reduction in the symptoms of aggression, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #3] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #3's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the prescribing physician at each follow-up appointment for a decision to be made on whether a deduction is appropriate." Client #3's BSP did not indicate the targeted behaviors for which each medication was taken and did not include the use of Buspirone and/or a plan of reduction for the Buspirone. Client #3's BSP indicated no specific plan</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's 8/1/13 physician's orders indicated client #4 took the following medications for behavior modification: Wellbutrin 300 mg qd, Risperidone 2 mg bid, Zoloft 200 mg qd and Ambien 10 mg qhs. Client #4's BSP of 11/20/12 indicated client #4 had targeted behaviors of agitation, crying, physical aggression and dangerous eating. Client #4's BSP indicated client #4 was taking Wellbutrin 300 mg qd, Risperdal 2 mg bid, Zoloft 150 mg qd and Ambien 5 mg qhs.</p> <p>__ Client #4's BSP indicated a plan of reduction for Wellbutrin, Zoloft and Risperdal to be "If [client #4] continues to show progress in her replacement behavior objective and if there is a reduction in the symptoms of aggression, the team will consider a reduction in psychotropic medication at least annually. The overall plan would be to have [client #4] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>discussed at [client #4's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the prescribing physician at each follow-up appointment for a decision to be made on whether a deduction is appropriate."</p> <p>__ Client #4's BSP indicated a plan of reduction for the Ambien to be "If [client #4] continues to show a stable sleep pattern and if there is a reduction in sleep-related difficulties, the team will consider a medication reduction. Unless clinical contraindication exists, such as ongoing sleep difficulties or unstable sleep pattern, a medication reduction should be attempted at least annually. The overall plan would be to have [client #4] on the least amount of psychotropic medication while allowing her the greatest level of participation in her life. This should always be balanced with a risk versus benefit assessment of her overall med regimen. The pros and cons of a medication reduction should be discussed at [client #4's] semiannual and annual meeting with thorough review of behavioral data and observation/input from the team. This information will then be presented to the prescribing physician at each follow-up appointment for a decision to be made on whether a deduction is appropriate." Client #4's BSP</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>did not include the use of Buspirone and/or a plan of reduction for the Buspirone. Client #4's BSP indicated no specific plan of reduction to reduce and eventually eliminate the behaviors for which each psychoactive medication was to target.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/14/13 at 3 PM indicated client #1's, #3's and #4's BSPs included the same titration criteria and were not specific to the clients' behaviors for which each psychoactive medication was to target.</p> <p>9-3-5(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 additional clients (#6 and #7), the facility nurse failed to ensure clients #6 and #7 received timely medical services and to ensure all of client #6's medications were labeled.</p> <p>Findings include:</p> <p>1. Client #7's record was reviewed on 8/14/13 at 3 PM.</p> <p>__ Client #7's Heath Care/Mental Status Concern Form of 6/4/13 "For the past few days while brushing [client #7's] teeth, she does fine with the whole bottom and top left. When I (the staff) get to the top right side she pulls back like something on that side hurts. If I try to brush any more, she closes her mouth tightly." The form indicated "[Name of doctor] appt. (appointment)."</p> <p>__ Client #7's Heath Care/Mental Status Concern Form of 6/29/13 indicated "[Client #7] seems like she has a bad toothache. She has been making faces like she is in a lot of pain when she is chewing. She is also only putting food in the left side of her mouth and only chewing on the left side." The form indicated "[Name of doctor] appt."</p>	W000331	All staff will receive retraining by the LPN on the policy for obtaining medical treatment and the on call policy so supervisors are not waiting to receive written reports of injury when medical treatment may be needed. A designated professional staff will provide on call at all times to the group home to ensure that direction can be provided to staff regarding medical treatment within a timely manner. The professional staff will be retrained to address any medical concerns in a timely manner and follow up to ensure all concerns have been properly followed up with. The director will sign off on retraining and will ensure compliance by monitoring and initialing all accident injury reports. Staff have been retrained on medication administration which includes only administering medications that are properly labeled. The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>Client #7's dental exam forms indicated: __7/23/13 "Refer to [name of oral surgeon] for evaluation." __7/25/13 "Unable to perform intraoral exam due to lack of pt (patient) cooperation. Pt has right facial swelling most likely due to infection lower right tooth." __8/8/13 "Dr (doctor) unable to examine [client #7] uncooperative. No x-rays sent from [name of hospital dental services]. Will schedule another appt." and was signed by the facility LPN (Licensed Practical Nurse)."</p> <p>Client #7's nursing notes indicated no notes from 6/4/13 until 7/22/13 in regard to the Heath Care/Mental Status Concern Forms documenting staffs' concern for client #7 reported on 6/4/13 and 6/29/13.</p> <p>Client #7's nursing notes indicated: 7/22/13 client #7 saw (name of doctor) for "swelling to right jaw, neck area" and was given Clindamycin (an antibiotic). The note indicated client #7 was to follow up with [name of oral surgeon]. 7/24/13 "Rt (right) facial swelling cont. (continued). [Initials of client #7] flinches with any touch to area. Remains red and inflamed. Ibuprofen per prn (as needed) orders for pain." 7/25/13 "Swelling decreasing. Hard center knot still remains tender, slightly red.</p>		of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Regional Director will ensure staff receive this retraining and will sign off on all Record of Trainings.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>Clindamycin cont."</p> <p>7/26/13 this nurse spoke with [name of oral surgeon's] office regarding plan of treatment. Extraction under GA (general anesthesia) is recommended according to office staff. No available date until August 14. This nurse to consult local oral surgeon due to length of wait."</p> <p>7/26/13 "Please assess [client #7] for discomfort/pain every 6 hours.... and medicate with Acetaminophen/Ibuprofen PRN."</p> <p>7/29/13 "Spoke with [name of local oral surgeon's office assistant] at [name of oral surgeon's] office in [name of city]. Explained situation. [Name of oral surgeon] (usual dentist) is out of town. Need appt prior to 8/23/13 ([name of oral surgeon's] first available appt.). Appt with [name of local oral surgeon] 8/8/13."</p> <p>The facility LPN was interviewed on 8/16/13 at 11 AM. The facility LPN indicated the Health Care Concern forms were completed by the staff when the staff had a medical concern with one of the clients. The LPN indicated the forms then went to the house manager and the house manager forwarded the forms to the LPN at which time the LPN would address the staff's health care concerns for the client. When asked why it took so long for client #7 to be seen for dental concerns after the staff noted it on 6/4/13</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>and again on 6/29/13, the LPN indicated the earliest she could get client #7 into the dentist was 7/23/13 at which time client #7 was referred to an oral surgeon. The LPN stated client #7 was put on antibiotics and given pain medication to "ease the discomfort until I could get her seen." The LPN indicated the oral surgeon saw clients in town but had the clients reschedule for needed procedures weeks later and at a facility located a long distance from the client's home. The LPN indicated on 7/29/13 she called a local oral surgeon to see if he would take client #7 and the doctor agreed but wanted client #7's dental records sent to him prior to doing anything for client #7. The LPN indicated she was still waiting on client #7's records to be released and sent to the local oral surgeon so client #7 could be seen for "possible dental surgery under anesthesia."</p> <p>2. Client #6's record was reviewed on 8/14/13 at 3 PM. Client #6's Health Care/Mental Status Concern Form of 6/8/13 (Saturday) indicated the staff reported client #6's urine had "a mildly fishy, salty smelling urine. Not a normal urine odor." The form indicated the house supervisor signed the note on 6/10/13 (Monday) and the LPN got it on 6/11/13 (Tuesday).</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>The report indicated client #6 did not have a urinalysis completed until 6/17/13 and then did not see her physician until 6/27/13.</p> <p>The facility LPN was interviewed on 8/16/13 at 11 AM. The LPN indicated she got the concern on 6/11/13 and the staff were instructed to increase fluids. The LPN indicated the client did not see the doctor when the staff first noted client #6's symptoms because "None of the doctors were in the office at the time." The LPN indicated client #6 had a urinalysis on 6/17/13 and saw her physician on 6/27/13. The LPN indicated client #6's urinalysis was normal by the time client #6 saw her physician.</p> <p>3. Observations were conducted of the morning medication pass at the group home on 8/14/13 between 6:20 AM and 8:55 AM. At 8:55 AM staff #6 gave client #6 a tube of medicated lip balm to put on her lips. The tube of medicated lip balm was not labeled with the client's name, name of medication, dosage and/or the times to be administered.</p> <p>Interview with staff #6 on 8/14/13 at 8:57 AM indicated the tube of lip balm was purchased over the counter and had never had a label on it. Staff #6 indicated all medications were to be labeled with the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>client's name, dosage and when it is to be given.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/14/13 at 11 AM indicated all medications were to have a pharmacy label with the client's name, the name of the medication, dosage and time the medication was to be given.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
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.</p> <p>Based on record review and interview for 3 of 4 sample clients (#1, #3 and #4) and 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients' medications were administered as prescribed per the clients' physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable records were reviewed from August 2012 through August 2013 on 8/13/13 at 11:25 AM. The BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>On 9/19/12 at 8 AM "During a med pass it was discovered that [client #6] had been given another consumer's 325 mg (milligram) Acetaminophen (for pain) PRN (as needed). [Client #6] is also prescribed this medication for pain. This error occurred 9/17, 9/18, and 9/19." The report indicated the staff would be retrained.</p> <p>On 10/13/12 at 10 PM "During a buddy medication administration check on 10/13 staff noticed [client #7's] Phenobarb (for seizures) 64.8 mg for the that (sic) PM</p>	W000368	<p>Staff have been retrained on medication administration. Also staff have been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be trained again on the Preventing Medication Errors handout and on the updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly. All residents are affected and corrective action will address the needs of all clients. The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors. Staff has been retrained on the importance of taking their time</p>	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>was still in the packaging. The staff contacted the group home nurse of the error and they were instructed to go ahead and give the medication. The next morning staff went to administer the same medication and discovered the pill was missing for the AM and had been given last night by mistake at 8 PM. As a result of these errors [client #7] received the medication 3 times 7 AM, 8 PM, and then again, at 10 PM." The report indicated the staff would be retrained.</p> <p>On 10/21/12 at 8 PM "During a buddy check it was discovered that [client #6] was given her nightly dose of Donepezil HCL (hydrochloride - for dementia) 10 mg twice, once at 7 PM and again at 8 PM. The pill is prescribed to be taken on an empty stomach so it is given prior to the rest of her medications. When it came time for the remainder of her medications to be given at 8 PM the pill was administered again." The report indicated the staff would be retrained.</p> <p>On 11/25/12 at 9 PM client #3's "medications were all packed in separate packages for each day, for a holiday home visit. [Client #3] was scheduled to (sic) on leave until 11/25 so her medications for 11/25 were all packed to be administered by family. [Client #3's] family contacted staff who then contacted</p>		<p>and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration. The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations. The Regional Director will ensure staff receive this retraining and will sign off on all Record of Trainings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>the group home nurse and informed her that family was unable to locate [client #3's] medications for 11/25. [Client #3's] family signed out these medications confirming that they had them in their possession."</p> <p>On 11/30/12 at 8 PM "During a medication audit conducted by the Team Leader of the house it was discovered that [client #5] was given one of two tablets of Carbamazepine (for seizures) 100 mg." The report indicated this error was not discovered until 12/4/12. The report indicated the staff would be retrained.</p> <p>On 1/28/13 at 8 PM "During AM med pass on 1/29 the staff contacted the nurse and informed her that [client #8] had not been given her Chlorhexidine mouthwash (for oral health) during 8 PM med pass on 1/28." The report indicated the staff would be retrained.</p> <p>On 1/31/13 at 4 PM indicated "During [client #4's] 8 PM medication pass, staff discovered that [client #4] was not given her 4 PM dose of Oxybutynin (for bladder problems) 5 mg as prescribed." The report indicated the staff would be retrained.</p> <p>On 2/15/13 at 7 AM "[Client #6] was not given her 7 AM dose of Bactrim antibiotic for the treatment of a urinary</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>tract infection. This error was not discovered until 2/16 at approx (approximately) 12:10 AM." The report indicated the staff would be retrained.</p> <p>On 2/10/13 at 4 PM "[Client #4] was not given her 4 PM dose of Oxybutynin 5 mg at 4 PM. Client #4 was on a visit with her father at 4 PM when the medication is prescribed to be given. [Client #4] however returned at 4:30 PM and could have been given the medication within the 1 hour window but staff got involved with other issues and forgot that she had not been given it." The report indicated the staff would be retrained.</p> <p>On 2/20/13 at 12 AM "[Client #8's] Nystop Anti-Fungal powder was not administered at 12 AM. This powder is administered twice a day to help prevent fungal growth in the folds of the pelvic area." The report indicated the staff would be retrained.</p> <p>On 3/8/13 at 8 PM "[Client #7] was not given her 8 PM dose of Flagyl 500 mg which is used to treat a vaginal infection." The report indicated the staff would be retrained.</p> <p>On 4/12/13 at 7 PM "[Client #6] was not given her Donepezil 10 mg on 4/12 at 7 PM. This medication is used for the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>treatment of dementia symptoms." The report indicated the staff would be retrained.</p> <p>On 7/1/13 "[Client #1] is prescribed Microgestin (birth control) for 3 weeks out of the month, the fourth week she is prescribed iron to prevent anemia during her menstrual cycle. These two medications arrive from the pharmacy in the same pack. Staff administered her birth control on 7/1/13 and 7/2/13 instead of following the MAR (Medication Administration Record) and administering the iron supplement." The report indicated the staff would be retrained.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/14/13 at 11 AM indicated all medications were to be given as prescribed by the clients' physicians. The LPN indicated the staff were retrained after the discovery of each medication error.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 5 of 84 medications observed being administered, the facility failed to ensure all medications were administered without error to clients #1, #2, #3, #5 and #7.</p> <p>Findings include:</p> <p>Observations were conducted of the morning medication pass at the group home on 8/14/13 between 6:20 AM and 8:55 AM. Clients #1 and #2 ate their breakfast of dry cereal, waffles, orange juice and milk between 6:30 AM and 7 AM.</p> <p>__At 6:20 AM staff #6 gave client #5 Tegretol (for seizures) 100 mg (milligram) chew along with all of her other AM medications in applesauce. Client #5 did not chew the Tegretol tablet. Client #5 swallowed the medication whole. The pharmacy orders on the bubble package of Tegretol indicated the medication was to be chewed.</p> <p>__At 7:18 AM staff #6 gave client #7 Phenytoin (for seizures) 50 mg chew along with all of her other AM</p>	W000369	<p>Staff have been retrained on medication administration which includes the right route and the right time. Also staff have also been trained on "Preventing Medication Errors," a handout written by the AWS Manager of Health Services and reminded to only pass medications as prescribed on the MAR. All staff will be retrained on the Preventing Medication Errors handout and updated Medication Error Disciplinary Procedure. The team leader will observe one medication pass for each staff monthly. The nurse or manager will observe one medication pass for the team leader monthly. All residents are affected and corrective action will address the needs of all clients. The East Central Indiana Medication Error Disciplinary Procedure has been updated to have staff suspended from passing medications after the second medication error, mandated to repeat Core A after the third medication error, and recommended for termination after the fourth medication error. This stricter procedure has been passed out to staff along with the handout written by the Manager of Health Services titled Preventing Medication Errors.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>medications in applesauce. Client #7 did not chew the Phenytoin tablet. Client #7 swallowed the medication whole. The pharmacy orders on the bubble package of Phenytoin indicated the medication was to be chewed.</p> <p>__ At 7:37 AM staff #6 placed some Desonide lotion into client #3's hand and client #3 applied it to her face. The pharmacy orders on the bottle indicated "Shake before using." Staff #6 was not observed to shake the bottle of lotion prior to giving it to client #3.</p> <p>__ At 8:20 AM staff #6 gave client #2 Omeprazole 20 mg. The pharmacy orders on the bubble package of Omeprazole indicated the medication was to be taken before food and/or a meal.</p> <p>__ At 8:55 AM staff #6 gave client #1 Omeprazole 20 mg. The pharmacy orders on the bubble package of Omeprazole indicated the medication was to be taken before food and/or a meal.</p> <p>Review of client #1's, #2's, #3's, #5's and #7's August 2013 MARs (Medication Administration Records) on 8/14/13 at 3:30 PM indicated:</p> <p>__ Clients #1 and #2 were to have Omeprazole 20 mg every morning. The MAR did not specify if the medication was to be taken before food and/or a meal.</p> <p>__ Client #5 was to chew her Tegretol</p>		<p>Staff has been retrained on the importance of taking their time and passing medications accurately. The Team Leader will observe one medication pass for each staff monthly and the nurse or manager will observe one medication pass for the team leader. This will ensure staff are continually passing medications as trained in Core A. The Manager of Health Services at AWS as well as a task force of AWS nurses are currently working on revising the internal Core A curriculum to ensure staff are being appropriately and comprehensively trained in Medication Administration. The Team Leaders will sign off on a medication observation sheet and turn it into the LPN and Group Home Manager monthly to ensure they are doing all required medication observations. The Regional Director will ensure staff receive this retraining and will sign off on all Record of Trainings.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>tablet. __ Client #7 was to chew her Phenytoin tablet.</p> <p>Review of client #1's, #2's, #3's, #5's and #7's physician's orders for August 2013 on 8/14/13 at 3:30 PM indicated: __ Clients #1 and #2 were to have Omeprazole every morning. The orders did not indicate the Omeprazole was to be given prior to food and/or a meal. __ Client #3 was to have Desonide lotion applied to her face twice daily. __ Client #5 was to have "Carbamazepine 100 mg tab (tablet) chew - IE Tegretol 100 mg tabl (tablet) give 1 tablet orally every morning." __ Client #7 was to have "Phenytoin 50 mg chew. Give 2 tablets orally twice daily for seizure disorder."</p> <p>Interview with the facility LPN (Licensed Practical Nurse) on 8/14/13 at 11 AM stated the staff were to follow the directives of the physician, the MAR and the pharmacy when passing medications and the staff "should have" ensured clients #1 and #2 received their Omeprazole prior to eating their morning meal "not after they ate." The LPN indicated the staff were to follow the pharmacy instructions on the medication bottles, boxes, bags and/or bubble packs.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	9-3-6(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
W000371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to develop medication objectives that provided medication training.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/14/13 at 12 PM. Client #1's 8/1/13 physician's orders indicated client #1 was taking Calcium, Cyclessa (a birth control pill), Enulose for constipation, Hydrochlorothiazide for high blood pressure, a multi vitamin and Wellbutrin, Depakote, Neurontin and Seroquel for behavior modification. Client #1's CFA (Comprehensive Functional Assessment) of 8/23/12 indicated client #1 was not independent with taking her medications and required staff assistance to locate the appropriate medication container and to identify her medication/dosage she was to take. Client #1's ISP (Individual Support Plan) of 9/4/12 indicated client #1 was to go to the staff when it was time for medications. Client #1's ISP indicated no</p>	W000371	Medication objectives have been updated to target the area of taking and/or identifying medications. An annual CFA will be completed for each consumer. Based on the CFA, medication objectives will be developed outlining the areas of necessary practice. These objectives will be accompanied by a methodology sheet outlining step by step how staff are to provide guidance and training in the specific area. Staff will be trained on all consumer objectives including the specific objective, how to document, how many prompts to give, and the frequency of the objective. Objectives will be revised annually or as needed due to consumer need. The QDDP will give the Regional Director each objective before it is put in place for a period of 3 months to ensure only well written and complete objectives are being implemented. After the 3 month time period the Regional Director will complete unannounced home visits to ensure objectives are in the home and being implemented appropriately. This visit will be documented on a home visit	09/20/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>training objectives to assist client #1 with taking and/or identifying her medications.</p> <p>Client #2's record was reviewed on 8/14/13 at 11 AM. Client #2's 8/1/13 physician's orders indicated client #2 was taking Acetaminophen for pain, Amlodipine and Lisinopril for high blood pressure, Evista for bone loss prevention, Tricor for high cholesterol, Glipizide and Januvia for blood sugar control, Levothyroxine for hypothyroidism, Lovastatin for hyperlipidemia, Magnesium Oxide and Calcium for dietary supplements, Singulair for breathing issues and Omeprazole to decrease stomach acid. Client #2's CFA of 8/23/12 indicated client #2 required staff assistance in taking and identifying medications and was unable to locate the appropriate medication containers. Client #2's ISP of 9/11/12 indicated client #2 was to wash her hands prior to taking her medications. Client #2's ISP indicated no training objectives to assist client #2 with taking and/or identifying her medications.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. Client #4's 8/1/13 physician's orders indicated client #4 was taking Wellbutrin, Risperidone and Sertraline for behavior modification, Calcium, Vitamin D and Thera Tablet for dietary supplements; Chlorhexidine Rinse</p>		form.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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
	<p>for oral health, Evista for bone loss prevention, Pepcid to decrease stomach acid, Metformin for blood sugar control, Oxybutynin for bladder control, Polyethylene Glycol Powder for constipation, Simvastatin for high cholesterol and Ambien for sleep. Client #4's CFA of 8/16/12 indicated client #4 required staff assistance in taking and identifying medications and was unable to locate the appropriate medication containers. Client #4's ISP of 9/13/12 indicated client #4 was to wash her hands prior to taking her medications. Client #4's ISP indicated no training objectives to assist client #4 with taking and/or identifying her medications.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/14/13 at 3 PM indicated client's #1, #2 and #4 were not independent in taking medications and required staff assistance to identify and prepare their medications. The QIDP indicated client #1 was to go to the staff when it was med time and clients #2 and #4 were to wash their hands prior to taking their medications. The QIDP indicated clients #1, #2 and #4 did not have any training objectives to assist clients #1, #2 and #4 with taking and/or identifying their medications.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 1 sampled client (#4) on a modified diet, the facility failed to ensure the staff provided food in accordance with the client's diet order.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/13/13 between 3:30 PM and 6:15 PM. Baked chicken, sweet potatoes, green beans, sliced bread and fruit cocktail were prepared for the evening meal. While the chicken was cooling, client #4 tore off pieces of baked chicken and ate them at a fast pace. For the evening meal client #4 ate two servings of baked chicken. The staff cut client #4's first serving of chicken into small pieces. After eating her first serving of chicken at a fast pace, client #4 took a second serving. The second serving of chicken was not cut into small pieces. Client #4 used her fingers to tear pieces of chicken apart and ate it at a fast pace.</p> <p>Client #4's record was reviewed on 8/14/13 at 2 PM. __ Client #4's 8/1/13 physician's orders indicated client #4 was to have a "1500</p>	W000460	<p>Staff will be retrained on monitoring and implementing diets, ISPs, BSPs and other risk plans. Staff will be retrained on each consumer's ISP, BSP and all risk plans before working with them and at least annually thereafter. These trainings are documented on a client specific training form and retained by Human Resources. Staff will be trained by the QDDP on goal tracking and following ISP and BSP. Staff will be trained by the LPN on following risk plans. The dietician will visit the home quarterly to monitor diet plans and meet with staff. The dietician visited the home in August and will be there again in November. The LPN will implement all recommendations will train staff on all recommendations given by the dietician. The dietician also attended a staff training meeting in September to offer onsite training directly to the staff. The Regional Director will sign off on these record of trainings to ensure staff are comprehensively trained.</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>calorie diet, soft cooked foods chopped into bite size pieces." __ Client #4's Quarterly Nutrition Review of 5/13/13 indicated client #4 was to have a "1500 calorie diet with soft cooked foods, chopped up into bite size pieces." __ Client #4's 10/1/12 Risk Summary indicated client #4 was at risk of choking. The plan indicated "Staff will be sure that [client #4] is given a mechanical soft diet..."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the facility LPN (Licensed Practical Nurse) on 8/16/13 at 11 AM indicated client #4's food was to be soft and cut into bite sized pieces. When asked if whole pieces of baked chicken were considered to be soft food, the LPN stated, "No, the staff should have cut it into small bite sized pieces for her [client #4]."</p> <p>9-3-8(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
W009999	<p>1. State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 additional client (#7), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law regarding the use of general anesthesia for a dental procedure.</p> <p>Findings include:</p> <p>Client #7's record was reviewed on 8/14/13 at 3 PM. Client #7's record indicated client #7 had a dental exam under general anesthesia on 3/29/13.</p> <p>The facility reportable and investigative</p>	W009999	<p>Training will be provided for all staff on reporting reportable incidents. This training will include training on what is reportable and reporting immediately to the QDDP or the LPN. The QDDP will notify the Regional Director and BDDS within 24 hours. All residents are affected and corrective action will address the needs of all clients. All staff will be trained on what incidents are reportable and the need for reporting reportable incidents to the QDDP or LPN immediately. The QDDP will notify the Regional Director and BDDS within 24 hours. The QDDP is responsible for ensuring the Regional Director and BDDS are notified of reportable incidents within 24 hours. The QDDP is supervised by the Regional Director. The Regional Director will sign off on all records of training ensuring all staff are trained. All new hires will receive three complete reference checks. This has been relayed by HR to the staff responsible for reference checks. If a reference refuses to release full information that reference will not be used and another reference will be contacted. All consumers could potentially be affected and the corrective action will address the need to protect all consumers. HR has been instructed to receive 3 complete reference checks for</p>	09/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374			
(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			
	<p>records for August 2012 through August 2013 were reviewed on 8/13/13 at 11:25 AM. The facility records indicated no reports for client #7 in regard to the need for sedation for a dental exam and surgical extraction of teeth.</p> <p>Interview with the facility LPN (Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional) on 8/14/13 at 3 PM indicated client #7's dental exam and surgical extractions were conducted under general anesthesia. The QIDP indicated client #7's exam under anesthesia and surgical extraction of teeth requiring the need for sedation was not reported to BDDS.</p> <p>9-3-1(a)</p> <p>2. State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met:</p> <p>460 IAC 9-3-2(a) Resident Protections</p> <p>"The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three</p>		<p>all new hires. The Richmond HR coordinator will review all new hires to ensure there are 3 complete reference checks present before calling them for new hire screenings. If a new hire does not have 3 complete reference checks that person will not be called until AWS has received other references to contact.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374		
(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	
	<p>(3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section."</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 2 of 4 personnel files reviewed (staff #3 and #4), the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility personnel records were reviewed on 8/13/13 at 11 AM. Staff #3's and #4's employee files indicated 1 of 3 references verifying only employment dates by previous employers.</p> <p>Interview with administrative assistant #1 on 8/13/13 at 11:30 AM indicated 1 of the 3 references for staff #3 and #4 provided only verification of previous employment dates. Administrative assistant #1 indicated staff #3 and #4 had not provided any further references for review.</p> <p>9-3-2(a)</p>				