

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2012
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NAME OF PROVIDER OR SUPPLIER AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 9824 TRENTMAN RD FORT WAYNE, IN 46816
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: September 18, 19 and 20, 2012.</p> <p>Facility number: 011504 Provider number: 15G741 AIM number: 200889050</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiency reflects state findings in accordance with 460 IAC 9. Quality Review completed 9/25/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to assure all medications were administered in compliance with physician's orders as indicated in 1 of 1 documented medication error reviewed involving client #5 who was a former resident of the home.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/18/12 at 12:31 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following medication error.</p> <p>A BDDS report dated 12/13/11 indicated "On 12/12/11 it was discovered that a transcription error occurred on 12/1/11 on the MAR (medication administration record). [Client #5's] Lamictal (antiepileptic) 100 mg (milligrams) bid (twice a day) was only given once daily for 10 (ten) days. It was corrected when it was discovered so he (client #5) is now receiving his Lamictal 100 mg twice a day. He receives Lamictal at 8:00 A.M. and 8:00 P.M. and the 8:00 P.M. dose was left off of the MAR accidentally when the</p>	W0368	<p>When the error was discovered, the nurse who transcribed the order incorrectly was immediately retrained and counseled on double checking the MAR after completing them each month. Documentation of this training was completed on 12/12/11. All DSP's and the house manager received retraining on the medication administration policy and comparing the physicians order to the MARS to catch any discrepancies and to prevent future medication errors of this nature. Documentation of this training was completed on 12/12/11. There have not been any medication errors for Client #5 since this incident nor any transcription errors of this nature. Managers/Nurses continue to complete weekly checks of medication administration and this is documented on the medication administration tracking form. This includes checking the medication cabinet, MAR, and completing medication passing observations. This form is turned into the director monthly and monitored for compliance and to monitor that the training was effective.</p>	10/20/2012			

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	<p>change over occurred at the beginning of the month. The Residential Director, Nurse, and Guardian were all notified. [Client #5's] doctor was notified and indicated that there are no risks to client health and safety and to resume his prescribed dosage with no other recommendations. [Client #5] did not have any adverse reactions. He has a pre-scheduled appointment with his neurologist on 12/29/11. The nurse who transcribed the medication incorrectly was retrained and counseled on double checking the MAR after completing them each month. Also the manager and staff were also retrained on the medication administration policy and comparing the physician's order to the MAR to catch any discrepancies to prevent this from happening again."</p> <p>Direct Care Staff (DCS) #6 was interviewed on 9/19/12 at 8:28 A.M.. When asked how medication changes are documented on the MAR, DCS #6 stated, "Usually the supervisor or the nurse writes any changes on the MAR. We are not allowed to write it in until the pill actually arrives in the home and we are told to give it."</p> <p>The facility nurse was interviewed on 9/20/12 at 12:30 P.M.. When asked about the medication error for client #5, the</p>				

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	<p>nurse stated, "I wrote down one time rather than two times. It was just a mistake; the staff thought it had been changed. He was to get the Lamictal twice a day for seizures."</p> <p>The Residential Director (RD) was interviewed on 9/20/12 at 12:35 P.M.. When asked about the medication error, the RD stated, "Staff thought it was a medication change. We retrained staff to complete their checks at each medication pass. There were no negative effects for [client #5], and no increased seizures." The RD indicated the medication transcription error should have been caught by the staff when they passed client #5 his medications.</p> <p>9-3-6(a)</p>				