PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
15G521		15G521	B. WING		05/09/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8		AMLIE RD		
AWS				WAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
W000000						
			W000000			
	This visit was for a fundamental		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	recertification at	nd state licensure survey.				
	Dates of survey: May 7, 8 and 9, 2014					
	Facility number:	001035				
	Provider number: 15G521					
	AIM number: 1					
	7 Mivi number. 1	00237020				
	Surveyor:					
	Susan Reichert,	OIDP				
	Susuii Referencit,	QID1				
	The following federal deficiency also					
	reflects state findings in accordance with					
	460 IAC 9.	amgs in accordance with				
		npleted 5/16/14 by Ruth				
	Shackelford, QIDP					
	Shackenora, QIBI	•				
14/000000	400, 400 (1) (0)					
W000369	483.460(k)(2) DRUG ADMINIST	DATION				
		ug administration must				
		gs, including those that				
		red, are administered				
	without error.					
	Based on observ	ration, record review and	W000369	On June 8, 2014 all staff	06/08/2014	
		cility failed for 1 of 3		will have received additional		
	clients (client #4	-		training on the medication		
	,	administer medications		administration policies and	dina	
	· ·			procedures. This includes read each and every instruction for		
	per physician's o	orders.		the medication on the MAR's h		
				been reviewed to ensure all		
	Findings include	: :		special instructions from the		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G521		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/09/2014		
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7614 LAMLIE RD FORT WAYNE, IN 46818				
(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
	group home on 5 until 7:31 AM. A her breakfast. Du administration of staff #1 gave clie (micrograms) for indicated client # medication 30 m meal of the day. medication administration reducation administration reduces for 5/14 v at 6:34 AM and to receive Linzer first meal of the Staff #1 was intended to th	ent #4 Linzess 145 mcg r constipation. The label #4 was to receive the inutes prior to the first Client #4 left the nistration area and went to finish her breakfast. (medication ecord) and physician's were reviewed on 5/8/14 indicated client #4 was as 30 minutes prior to the day.			physician are being implement as prescribed. The manager is residential nurse will also reviall new MAR's to ensure that a special instructions are implemented as prescribed by physician. The manager and nurse will continue to complet weekly checks on an ongoing basis of medication administration, which is documented on the medication administration tracking form. Includes checking the medicatic cabinet, MAR and completing medication passing observation. This form is turned into the director monthly and is monitor for compliance to ensure the effectiveness of the training.	and ew all the e n his tion ons.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J3D011

Facility ID: 001035

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G521	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 05/0 9			
NAME OF PROVIDER OR SUPPLIER AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 7614 LAMLIE RD FORT WAYNE, IN 46818					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE			
	copy of a note signed by client #4's physician which stated it would not be harmful for client #4 "occasionally" not to wait to eat breakfast 30 minutes after receiving her medication. The RD indicated staff should follow the instructions on the medication label and the MAR. 9-3-6(a)							

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If continuation sheet

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