

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/03/2014
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 4420 WOODSTOCK DR FORT WAYNE, IN 46815
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 30, 31 and November 3, 2014.</p> <p>Facility number: 000713 Provider number: 15G180 AIM number: 100243170</p> <p>Surveyor: Kathy J. Wanner, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 10, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000209	<p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to aggressively pursue the participation of parents, advocates and legal representatives in the Individual Support Plan (ISP) process for 1 of 3 sampled clients (client #2).</p>	W000209	<p>Client #2's ISP will be sent to his guardian and signature will be obtained indicating that she reviewed it Person Responsible: QIDP Completion Date: December 3, 2014 The QIDPs will be retrained to always send ISPs to guardians for a</p>	12/03/2014

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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W000368	<p>Findings include:</p> <p>Client #2's record was reviewed on 11/3/14 at 11:65 A.M. Client #2's record indicated his sister was his guardian. Client #2's ISP was dated 1/23/14. Client #2's record did not indicate the facility aggressively pursued client #2 guardian in the participation of the formation of client #2's plans.</p> <p>The Assistant Residential Director (ARD) was interviewed on 11/3/14 at 2:10 P.M. The ARD stated, " [Client #2's] guardian doesn't normally attend his meetings. We send the ISP and a signature page to guardians for signatures. I am unable to locate the signature page and I do not have any proof we mailed it to her. We went through several Qualified Intellectual Disabilities Professionals (QIDPs) since his ISP, it must have been misplaced."</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>		<p>signature Person responsible: Assistant Director Completion Date: December 3, 2014 The Assistant Director of Supported Living completed an audit of client records to ensure that guardians have received and signed all ISPs. All other clients ISPs have been signed by the guardian. No other clients were affected by the deficient practice. The assistant director will complete quarterly audits of client records on an ongoing basis Person Responsible: Assistant Director Supported Living Completion Date: December 1, 2014 and ongoing</p>		

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	<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 drugs were administered in compliance with physician's orders (PO) for 2 of 3 sampled clients (client #1 and #3).</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/30/14 at 2:25 P.M. including the Bureau Of Developmental Disabilities Services (BDDS) reports. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 8/2/14 for an incident on 8/1/14 at 6:00 A.M. indicated "On August 1, [client #1] did not receive the following medication: Amlodipine 5 mg (milligrams) for high blood pressure, calcium carbonate with vitamin D3 supplement, Carbamazepine 200 mg for seizures, Ascorbic Acid supplement, Lisinopril 5mg for blood pressure and Trifluoperazine 6mg for mood. The staff signed for medications, when supervisor spoke to staff they stated they had given the meds (medication) but the pills for the first of August were still in the bubble pack and no other pills were missing from any of the dates still present. Staff will monitor [client #1] to make sure he</p>	W000368	<p>The group home staff will be retrained on Easter Seals Arc's medication administration policy and the buddy check system Person Responsible: QIDP Completion Date: December 3, 2014 The persons responsible for the med errors will be retrained and receive a supervised med pass. They will not be able to pass medication until they've passed the supervised med pass Person Responsible: House Supervisor Completion Date: December 3, 2014 All group home staff will receive a supervised med pass. They will not be able to pass medications until they have passed the supervised med pass. Person Responsible: House Supervisor Completion Date: December 3, 2014 All supported living staff will receive a supervised med pass quarterly including all group home staff and any staff that work as substitutes for regular staff. Person Responsible: Supported Living Supervisors Completion Date: Ongoing All supported living staff including all group home staff as well as any staff that work as substitutes for regular staff will attend a Core A refresher class taught by a nurse annually Person Responsible: Agency Nurse Completion Date: Ongoing</p>	12/03/2014	

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	<p>has no consequences from 5 the missed medications. The nurse was notified on 8/2/14 but it was to late to give him any of the missed medications. Staff responsible will receive discipline and the entire home will have another in service on the buddy system for checking medications."</p> <p>-a BDDS report dated 8/12/14 for an incident on 8/10/14 at 6:00 A.M. indicated "...On August 10th [client #1] did not receive the following medications: Amlodipine 5 mg for high blood pressure, calcium carbonate with vitamin D3 supplement, Carbamazepine 200 mg for seizures, Ascorbic Acid supplement and Lisinopril 5mg for blood pressure. The error was discovered on 8/11/14. [Client #1] did not have any adverse side effects from the missed doses of medication. The agency's nurse practioner was notified of the missed medications. Staff will receive disciplinary action and retraining on the medication administration policy."</p> <p>Client #1's record was reviewed on 11/3/14 at 10:45 A.M. Client #1's Medication Administration Record (MAR) dated for 9/2014 indicated Client #1 was prescribed the medications as indicated above.</p>						

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	<p>-a BDDS report dated 8/29/14 for an incident on 8/28/14 at 7:30 A.M. indicated "Yesterday morning staff did not give [client #3] his 7:30 A.M. meds (medication): Folic Acid 1mg (supplement) and Glipizide one-half of a 5mg tablet (2.5 mg) (anti diabetic). The medications were found to be still in the medication packs this morning by staff. At 9:58 A.M. today, staff called the agency nurse and reported that he (client #3) did not get his 7:30 A.M. medications. The nurse looked it up in the electronic MAR system and told them that it had been signed for but if they are still in the pack they should give them to him. The nurse explained that it was better to give them a little late than not at all. The staff never told the nurse the missed medications were from the day before. Staff went ahead and gave him (client #3) his 7:30 A.M. meds again at 10:00 A.M. today which resulted in him being double dosed. Staff informed the supervisor of what happened at 12 noon today. The supervisor called the nurse and explained the situation. [Client #3] has not had any adverse reactions from the missed doses and then the double doses of medication. Staff will be monitoring his (client #3's) blood sugar carefully this afternoon and evening. Staff will be trained to be clear about dates and times when talking to the nurse</p>			

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	<p>regarding medications."</p> <p>Client #3's record was reviewed on 11/3/14 at 12:19 P.M. Client #3's Medication Administration Record (MAR) dated for 9/2014 indicated Client #3 was prescribed the medications as indicated above.</p> <p>An interview was conducted with the RN for the group home where clients #1 and #3 lived on 11/3/14 at 2:30 P.M. The RN stated, "The medication errors didn't cause any harm. Yeah, they were significant medication errors. The staff passing medications at the times was not a regular staff and she didn't realize she had missed the medications."</p> <p>An interview was conducted with the Assistant Residential Director (ARD) on 11/3/14 at 2:10 P.M. The ARD stated, "There were some temp (temporary) staff working there and a peer (client #6) was having a behavior issues and attempting to walk alone staff assisted the peer and never ended up giving the medications the one incident. We do have a buddy system. The next shift that comes in to work checks that the previous shift passed, no it is not done at the time of the medication passes."</p> <p>9-3-6(a)</p>						

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

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