

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G415	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/07/2015
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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W 000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00169163.</p> <p>Complaint #IN00169163, Substantiated. Federal and State deficiencies related to the allegations are cited at W104, W149, W249 and W268.</p> <p>Dates of survey: April 2, 6 and 7, 2015.</p> <p>Facility number: 000929 Provider number: 15G415 AIM number: 100244520</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 104  Bldg. 00	<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 record review and interview, the governing body failed to exercise general policy and operating direction</p>	W 104	TheDepartment Director has given a list of group homes that do not require liftingto the Schedulers. PersonResponsible:	05/07/2015

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

TITLE

(X6) DATE

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

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	<p>over the group home by the Department Director (DD) and House Supervisor (HS) failing to ensure the group home was staffed by a staff who was able to meet all the requirements of the position and ensure the physical needs of 2 of 2 sampled clients (clients A and B) could be met throughout the overnight shift.</p> <p>Findings include:</p> <p>Facility records were reviewed on 4/6/2015 at 12:50 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/2015 and 4/6/2015. The BDDS reports indicated the following:</p> <p>A BDDS report dated 3/7/2015 for an incident on 3/7/2015 at 7:00 A.M. indicated "On March 7, 2015... was informed that [client A] was crying the night of 3/6/2015 because she wanted to use the bathroom and [name of staff #1] wouldn't take her; that she wet the bed in the morning. [Staff #1] didn't change her."</p> <p>The facility's internal investigation documentation and summary by the Abuse, Neglect, and Exploitation (ANE) Committee dated 3/12/2015 were reviewed on 4/6/2015 at 2:45 P.M. and</p>		<p>Department Director CompletionDate: 4/13/15 The Schedulerswill be trained on the appropriate placement of staff with lifting restrictions PersonResponsible: Call Center Supervisor CompletionDate: 5/7/15 The House Supervisorwill be trained on the appropriate placement of staff with lifting restrictions PersonResponsible: QIDP CompletionDate: 5/7/15 The QIDP willreview the house staffing daily for one week to ensure that all staff that workat the group home meet the requirements of the position and then weekly for aperiod of 3 months. The QIDP will continue to review the house staffing monthlyongoing. Person Responsible:QIDP CompletionDate: 5/7/15</p>	

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	<p>indicated the following; "The committee did not substantiate neglect based on confirmed information that [staff #1] reported to management that she had a lifting restriction and they moved her to another house that required lifting. [Staff #1] also tried to change [client A] which was confirmed by another staff. The committee does recommend that [staff #1] receive retraining on properly reporting emergencies to on call. Regarding the allegation of neglect regarding [client A] the ANE Committee further recommends disciplinary action for the Department Director (DD) and House Supervisor (HS). HS [name] was told the employee had the weight restriction prior to the shift from scheduling. [Staff #1] also directly told [name of HS] when she arrived at the house that she was not comfortable working with [client A] in case she needed lifted and [HS] still had [staff #1] cover the shift and stated that [client A] could lift herself. The committee recommends a written warning and 90 day probation and proper retraining on client safety.</p> <p>The Department Director (DD), [name] did not follow-up with scheduling to confirm which house [staff #1] was assigned to after she knew about the lifting restriction. The DD left the decision up to scheduling to place [staff</p>			

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	<p>#1] in a home that did not require lifting instead of ensuring the situation was handled appropriately. Executive management staff determined the DD will be placed on a written warning and 90 day probation and proper retraining on client safety and proper placing staff (sic) with work restrictions."</p> <p>The facility investigation documentation included a physician's note for staff #1 indicating she was on a 20 pound weight lifting restriction.</p> <p>The facility investigation documentation indicated staff #1 had attempted to change client A while she was in her bed, but client A was unable to roll over due to her paralysis and weakness and staff #1 could not change client A or her bedding. A second staff (staff #2) arrived and she found client A crying about not being taken to the bathroom and being wet. Staff #2 noted client A's body was uncovered and it appeared as if staff #1 had been attempting to remove client A's soiled clothing. Staff #2 attempted to calm client A. Client A's father/guardian arrived as he normally does on Saturday mornings and he informed the staff he would get his daughter dressed and ready for the day. Client A's guardian requested that the staff not wake client A up on Saturday mornings until he had arrived,</p>			

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W 149  Bldg. 00	<p>so she would not get upset. During the investigation client B (client A's roommate) indicated she had observed client A crying and unclothed lying on client A's bed.</p> <p>The Quality Director (QD) was interviewed on 4/2/2015 at 3:16 P.M. When asked if the DD and HS had followed policy on staff working at the group home when they were on a weight lifting restriction, the QD stated. "No, they did not." The QD indicated both clients A and B would need assistance with transferring and ambulating, and a staff with a 20 pound weight restriction should not have been scheduled to work in their home. The QD indicated the DD and HS had failed to follow facility policies and procedures.</p> <p>This federal tag relates to complaint #IN00169163.</p> <p>9-3-1(a)</p> <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.</p>			
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	<p>Based on record review and interview, the facility failed to follow their Standard Operating Procedures and Personnel Policy by neglecting to ensure the group home was staffed by a staff who was able to meet all the requirements of the position and ensure the physical needs of 2 of 2 sampled clients (clients A and B) could be met throughout the overnight shift.</p> <p>Findings include:</p> <p>Facility records were reviewed on 4/6/2015 at 12:50 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/2015 and 4/6/2015. The BDDS reports indicated the following:</p> <p>A BDDS report dated 3/7/2015 for an incident on 3/7/2015 at 7:00 A.M. indicated "On March 7, 2015... was informed that [client A] was crying the night of 3/6/2015 because she wanted to use the bathroom and [name of staff #1] wouldn't take her; that she wet the bed in the morning. [Staff #1] didn't change her."</p> <p>The facility's internal investigation documentation and summary by the Abuse, Neglect, and Exploitation (ANE)</p>	W 149	<p>The Department Director has given a list of group homes that do not require lifting to the Schedulers.</p> <p>Person Responsible: Department Director Completion Date: 4/13/15</p> <p>The Schedulers will be trained on the appropriate placement of staff with lifting restrictions</p> <p>Person Responsible: Call Center Supervisor Completion Date: 5/7/15</p> <p>The House Supervisor will be trained on the appropriate placement of staff with lifting restrictions</p> <p>Person Responsible: QIDP Completion Date: 5/7/15</p> <p>The QIDP will review the house staffing daily for one week to ensure that all staff that work at the group home meet the requirements of the position and then weekly for a period of 3 months. The QIDP will continue to review the house staffing monthly ongoing.</p> <p>Person Responsible: QIDP Completion Date: 5/7/15</p>	05/07/2015

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	<p>Committee dated 3/12/2015 were reviewed on 4/6/2015 at 2:45 P.M. and indicated the following; "The committee did not substantiate neglect based on confirmed information that [staff #1] reported to management that she had a lifting restriction and they moved her to another house that required lifting. [Staff #1] also tried to change [client A] which was confirmed by another staff. The committee does recommend that [staff #1] receive retraining on properly reporting emergencies to on call. Regarding the allegation of neglect regarding [client A] the ANE Committee further recommends disciplinary action for the Department Director (DD) and House Supervisor (HS). HS [name] was told the employee had the weight restriction prior to the shift from scheduling. [Staff #1] also directly told [name of HS] when she arrived at the house that she was not comfortable working with [client A] in case she needed lifted and [HS] still had [staff #1] cover the shift and stated that [client A] could lift herself. The committee recommends a written warning and 90 day probation and proper retraining on client safety.</p> <p>The Department Director (DD), [name] did not follow-up with scheduling to confirm which house [staff #1] was assigned to after she knew about the</p>			

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	<p>lifting restriction. The DD left the decision up to scheduling to place [staff #1] in a home that did not require lifting instead of ensuring the situation was handled appropriately. Executive management staff determined the DD will be placed on a written warning and 90 day probation and proper retraining on client safety and proper placing staff (sic) with work restrictions."</p> <p>The facility investigation documentation included a physician's note for staff #1 indicating she was on a 20 pound weight lifting restriction.</p> <p>The facility investigation documentation indicated staff #1 had attempted to change client A while she was in her bed, but client A was unable to roll over due to her paralysis and weakness and staff #1 could not change client A or her bedding. A second staff (staff #2) arrived and she found client A crying about not being taken to the bathroom and being wet. Staff #2 noted client A's body was uncovered and it appeared as if staff #1 had been attempting to remove client A's soiled clothing. Staff #2 attempted to calm client A. Client A's father/guardian arrived as he normally does on Saturday mornings and he informed the staff he would get his daughter dressed and ready for the day. Client A's guardian requested</p>			

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	<p>that the staff not wake client A up on Saturday mornings until he had arrived, so she would not get upset. During the investigation client B (client A's roommate) indicated she had observed client A crying and unclothed lying on client A's bed.</p> <p>Client A's record was reviewed on 4/2/15 at 2:12 P.M. Client A's record indicated she had the following, but not limited to, diagnoses of cerebral palsy, seizures, left sided weakness, urinary incontinence, joint limitation or skeletal deformities and being overweight. Client A utilized a gait belt and staff assistance when transferring. Client A used a wheelchair for transportation. Staff were to ensure client A was clean and dry after each episode of incontinence.</p> <p>Client A's fall risk plan dated 1/8/15 indicated "[Client A] has had accidental falls from leaning forward in her wheelchair to pick something up off the floor, when transferring to toilet or shower from wheelchair."</p> <p>Client B's record was reviewed on 4/2/15 at 2:38 P.M. Client B's record indicated she had the following, but not limited to, diagnoses of cerebral palsy and seizure disorder. Client B ambulated with the use of a walker and a gait belt with one on one assistance from staff. Client B's</p>			

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	<p>record indicated the client had been experiencing increasing unsteadiness when ambulating and would be having a physical therapy evaluation.</p> <p>The facility's Standard Operating Procedures dated 3/23/2011 and the Staff and Client Relationships policy dated 2014 were reviewed on 4/6/15 at 9:09 A.M. The policy indicated "... 2. Alleged, suspected or actual neglect which includes but is not limited to: a. failure to provide appropriate supervision, care, or training. b. failure to provide a safe, clean and sanitary environment. c. failure to provide food and medical care as needed...10. Client safety is of utmost importance to the staff of [name of facility]. Abuse and neglect of clients will not be tolerated."</p> <p>The facility's Personnel Policy Manual dated 12/9/2014 was reviewed on 4/6/2015 at 10:02 A.M. and indicated: "[name of facility] does not have permanent light-duty positions. However, in the event that you are able to return to work following an injury, disability or other medical leave of absence before you are able to perform the essential functions of your regular position, [name of facility] may offer you a temporary light-duty assignment."</p>			

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W 249  Bldg. 00	<p>The Quality Director (QD) was interviewed on 4/2/2015 at 3:16 P.M. When asked if the facility had a policy on staff working at the group home when they were on a weight lifting restriction, the QD stated. "Yes, we do. Part of the requirements of the position are that staff must be able to lift 75 pounds. If they cannot lift 75 pounds, then they must be scheduled in a home that does not require any lifting." The QD indicated both clients A and B would need assistance with transferring and ambulating, and a staff with a 20 pound weight restriction should not have been scheduled to work in their home. The QD indicated the DD and HS had failed to follow facility policies and procedures.</p> <p>This federal tag relates to complaint #IN00169163.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active</p>			
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	<p>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 record review and interview, the facility failed to ensure the group home was staffed by a staff who was able to meet all the requirements of the position and ensure the physical needs and risk plans of 1 of 2 sampled clients (client A) could be met throughout the overnight shift.</p> <p>Findings include:</p> <p>Facility records were reviewed on 4/6/2015 at 12:50 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/2015 and 4/6/2015. The BDDS reports indicated the following:</p> <p>A BDDS report dated 3/7/2015 for an incident on 3/7/2015 at 7:00 A.M. indicated "On March 7, 2015... was informed that [client A] was crying the night of 3/6/2015 because she wanted to use the bathroom and [name of staff #1] wouldn't take her; that she wet the bed in the morning. [Staff #1] didn't change her."</p> <p>The facility investigation documentation</p>	W 249	<p>The Department Director has reviewed the individual service plans of each individual to assess the staffing needs at Standridge Group Home. Double staffing during the overnight hours has been implemented. Person Responsible: Department Director Completion Date: 4/10/15</p> <p>The Department Director will review each individual's service plan once a week for one month and then once a month for three months. The Department Director will review each individual's service plan quarterly thereafter. Person Responsible: Department Director Completion Date: 5/7/15</p> <p>The Department Director will train the QIDP and House Supervisor on proper implementation of needed interventions and services in sufficient number and frequency</p> <p>Person Responsible: Department Director Completion Date: 5/7/15</p> <p>The QIDP will conduct a weekly observation for one month and then monthly thereafter at the group home to ensure that interventions and services are being implemented in sufficient number and frequency</p> <p>Person Responsible: QIDP Completion Date: 5/7/15</p> <p>The Department Director will conduct monthly observations to</p>	05/07/2015

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	<p>indicated staff #1 had attempted to change client A while she was in her bed, but client A was unable to roll over due to her paralysis and weakness and staff #1 could not change client A or her bedding. A second staff (staff #2) arrived and she found client A crying about not being taken to the bathroom and being wet. Staff #2 noted client A's body was uncovered and it appeared as if staff #1 had been attempting to remove client A's soiled clothing. Staff #2 attempted to calm client A. Client A's father/guardian arrived as he normally does on Saturday mornings and he informed the staff he would get his daughter dressed and ready for the day. Client A's guardian requested that the staff not wake client A up on Saturday mornings until he had arrived, so she would not get upset. During the investigation client B (client A's roommate) indicated she had observed client A crying and unclothed lying on client A's bed.</p> <p>Client A's record was reviewed on 4/2/15 at 2:12 P.M. Client A's record indicated she had the following, but not limited to, diagnoses of cerebral palsy, seizures, left sided weakness, urinary incontinence, joint limitation or skeletal deformities and being overweight. Client A utilized a gait belt and staff assistance when transferring. Client A used a wheelchair</p>		<p>ensure that the interventions and services are being implemented in sufficient number and frequency once a month ongoing Person Responsible: Department Director Completion Date: 5/7/15</p>	

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W 268 Bldg. 00	<p>for transportation. Staff were to ensure client A was clean and dry after each episode of incontinence.</p> <p>Client A's fall risk plan dated 1/8/15 indicated "[Client A] has had accidental falls from leaning forward in her wheelchair to pick something up off the floor, when transferring to toilet or shower from wheelchair."</p> <p>The Quality Director (QD) was interviewed on 4/2/2015 at 3:16 P.M. When asked if staff #1 had followed client A's plans, QD stated. "No, they did not get her up to use the restroom. Her plans were not followed."</p> <p>This federal tag relates to complaint #IN00169163.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G415		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/07/2015	
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST				STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825			
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	<p>independence of the client.</p> <p>Based on record review and interview, the facility failed to ensure the group home staff promoted the dignity of 1 of 2 sampled clients (client A) by failing to ensuring she could use the restroom during the night and by failing to provide privacy during personal care.</p> <p>Findings include:</p> <p>Facility records were reviewed on 4/6/2015 at 12:50 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 1/1/2015 and 4/6/2015. The BDDS reports indicated the following:</p> <p>A BDDS report dated 3/7/2015 for an incident on 3/7/2015 at 7:00 A.M. indicated "On March 7, 2015... was informed that [client A] was crying the night of 3/6/2015 because she wanted to use the bathroom and [name of staff #1] wouldn't take her; that she wet the bed in the morning. [Staff #1] didn't change her."</p> <p>The facility investigation documentation indicated staff #1 had attempted to change client A while she was in her bed, but client A was unable to roll over due to her paralysis and weakness and staff</p>			W 268	<p>Group HomeStaff will be retrained on providing privacy during personal care and promotingthe dignity of each person</p> <p>PersonResponsible: QIDP CompletionDate: 5/7/15</p> <p>The housesupervisor will conduct a weekly observation ongoing to ensure that staff areproviding privacy during personal care and promoting the dignity of eachperson.</p> <p>PersonResponsible: House Supervisor CompletionDate: 5/7/15</p> <p>The QIDP willconduct an observation weekly for one month and then monthly ongoing to ensurethat staff are providing privacy during personal care and promoting the dignityof each person.</p> <p>PersonResponsible: QIDP CompletionDate: 5/7/15</p> <p>TheDepartment will conduct a monthly observation ongoing to ensure that staff areproviding privacy during personal care and promoting the dignity of eachperson.</p> <p>PersonResponsible: Department Director CompletionDate: 5/7/15</p>		05/07/2015

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	<p>#1 could not change client A or her bedding. A second staff (staff #2) arrived and she found client A crying about not being taken to the bathroom and being wet. Staff #2 noted client A's body was uncovered and it appeared as if staff #1 had been attempting to remove client A's soiled clothing. Staff #2 attempted to calm client A. Client A's father/guardian arrived as he normally does on Saturday mornings and he informed the staff he would get his daughter dressed and ready for the day. Client A's guardian requested that the staff not wake client A up on Saturday mornings until he had arrived, so she would not get upset. During the investigation client B (client A's roommate) indicated she had observed client A crying and unclothed lying on client A's bed.</p> <p>Client A's record was reviewed on 4/2/15 at 2:12 P.M. Client A's record indicated she had the following, but not limited to, diagnoses of cerebral palsy, seizures, left sided weakness, urinary incontinence, joint limitation or skeletal deformities and being overweight. Client A utilized a gait belt and staff assistance when transferring. Client A used a wheelchair for transportation. Staff were to ensure client A was clean and dry after each episode of incontinence.</p>			

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	<p>Client A's fall risk plan dated 1/8/15 indicated "[Client A] has had accidental falls from leaning forward in her wheelchair to pick something up off the floor, when transferring to toilet or shower from wheelchair."</p> <p>The Quality Director (QD) was interviewed on 4/2/2015 at 3:16 P.M. When asked if the staff had promoted client A's dignity by allowing her to remain wet and uncovered, the QD stated. "No, it was not dignified for her to have to lay wet."</p> <p>This federal tag relates to complaint #IN00169163.</p> <p>9-3-5(a)</p>			