

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G752	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2013
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9104 STRATHMORE LN FORT WAYNE, IN 46818
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 12, 13, 16, 23 and 24, 2013.</p> <p>Facility number: 011871 Provider number: 15G752 AIM number: 200921870</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/2/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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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, the facility failed to insure their Abuse and Neglect Policy was implemented by not preventing ongoing client to client physical aggression involving 1 of 3 sampled clients (client #2) towards 2 of 3 sampled clients (clients #1 and #3) and 2 of 3 additional clients (clients #4 and #5); and for 1 of 3 additional clients (client #5) by not following her Behavior Support Plan and using a refusal for an outing to lunch as punishment.</p> <p>Findings include:</p> <p>The facility records were reviewed on 9/13/13 at 11:09 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 9/12/12 through 9/13/13. The BDDS reports indicated the following:</p> <p>1. A BDDS report dated 9/14/12 for an incident on 9/14/12 at 4:15 P.M. indicated "This afternoon [client #2] hit [client #3] in the midsection. Staff immediately separated [client #2] and [client #3]. [Client #3] was evaluated by staff for pain and injury. [Client #3] expressed no pain and no injury was found. In the future</p>	W000149	<p>Group homestaff will be retrained on client #2 and client #5's behavior support plans. PersonResponsible: QIDPCompletionDate: October 24, 2013 Grouphome staff will be trained on abuse, neglect, and exploitation prevention PersonResponsible: QIDPCompletionDate: October 24, 2013 Ongoing,all staff will be trained on preventing abuse neglect and exploitation annually. PersonResponsible: Group home supervisorCompletionDate: October 24, 2013 Ongoing, toprevent further physical aggression, group home staff will have client #2 sitin the front seat and will load him into the van first. PersonResponsible: Group home supervisorCompletionDate: October 24, 2013</p>	10/24/2013	

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	<p>staff will monitor [client #3] and [client #2] more closely when they are in the same room."</p> <p>A BDDS report dated 12/7/12 for an incident on 12/6/12 at 3:30 P.M. indicated, "While the clients were on the van riding home from the day program, [Client #2] reportedly struck [client #5] on her face. Staff reports there were no visible triggers prior to the incident. [Client #5] appears to have suffered no injuries as a result of this incident. [Client #2] has a Behavior Support Plan (BSP) which addresses the targeted behavior of physical aggression. [Client #2] also has a Behavior Clinician (BC) who works with him on appropriate social behavior. [Client #2's] BC has been notified of this incident. [Client #2] has had 1 (one) other reported incident of physical abuse over the past year. Given this information, [client #2's] interdisciplinary team (IDT) does not feel that a change to his plan is needed at this time as his current BSP appears to be an effective tool at preventing acts of aggression with [client #2]. Should any future patterns of aggression develop, [client #2's] IDT will consider a needed change to his plan."</p> <p>A BDDS report dated 2/1/13 for an incident on 1/31/13 at 3:20 P.M. indicated "...while both individuals were riding the</p>			

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	<p>group home van after day programming, [client #2] grew agitated and struck [client #4] on his forearm. [Client #4] appears to have suffered no apparent injury as a result of this incident. Staff was able to verbally redirect [client #2] after the incident. Thus preventing further escalation. [Client #2] has a BSP in place which addresses the targeted behavior or (sic) physical aggression. [Client #2] also has a BC who has been informed of this incident. Staff were unable to identify a possible trigger for the incident. [Client #2] has had 1 (one) other reported incident of physical aggression involving another client within the past 6 (six) months. At present time, no changes appear to be needed to both clients' plans as no patterns of aggression appear to exist."</p> <p>A BDDS report dated 4/29/13 for an incident on 4/26/13 at 7:15 A.M. indicated while clients were riding the van to day program, "[Client #1] reportedly grew agitated and began yelling. This upset [client #2] who struck [client #1] on her arm in an effort to stop her from yelling out. [Client #1], in retaliation, struck [client #2] back on his arm. Staff were able to verbally redirect both clients before the situation was able to escalate further. Both clients have BSPs which address the targeted behavior</p>			

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	<p>of physical aggression. Neither client appears to have suffered any injuries as a result of these incidents. Both [client #2's] and [client #1's] BCs have been notified of this incident. [Client #2] had 1 (one) other reported incident of physical aggression in the last 6 (six) months. This was directed toward a different client. [Client #1] has not had any other reported incidents of physical aggression with another client in the last 1 (one) full year. At present time, no patterns of aggressive behavior appear to exist between both clients. No changes to both [client #1's] and [client #2's] plan appear to be needed at this time."</p> <p>A BDDS report dated 5/16/13 for an incident on 5/15/13 at 4:15 P.M. indicated "While loading the van...[client #2] smacked [client #3] on her arm...[Client #3] did not develop any injuries as a result of this incident. [Client #2] has a BSP which addresses the targeted behavior of physical aggression. He has a BC who helps him in appropriate social behavior. [Client #2] has had 1(one) other incident of physical aggression toward another client within the last 6 (six) months. This incident involved a different client. Thus, no patterns of aggression are apparent at the present time with [client #2]. [Client #2's] BC has been notified of this incident. At the present time, no</p>			
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	<p>changes appear to be needed to [client #2's] plan."</p> <p>A BDDS report dated 8/20/13 for an incident on 8/20/13 at 3:15 P.M. indicated "When [client #4] was getting into the van and sat down beside [client #2]. When [client #4] sat down besides (sic) [client #2] starting (sic) hitting him (client #4) in the shoulder and upper arm. Staff moved [client #4] away from [client #2] and counseled him not to hit [client #4] that he could have hurt him. [Client #2] apologized to [client #4] after talking with staff. Staff was present when the physical aggression took place. Staff will monitor [client #2] when he is the van (sic)."</p> <p>2. A BDDS report dated 6/21/13 for an incident on 6/21/13 at 7:00 A.M. indicated "[Client #5] told an agency nurse that her morning staff person [name of staff], told her that if she wet the bed she couldn't go to lunch." The staff was immediately suspended and the allegation of staff abuse was investigated. The summary of the investigation dated 6/28/13 indicated "The Abuse, Neglect and Exploitation committee met to review...the allegation that the staff denied an outing based on her wetting the bed. During the course of the investigation another allegation came to light regarding staff allegedly audio</p>			

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	<p>taping the client and also denying the client iced coffee because she wet the bed. The staff person admitted that she told the client they would not go out to lunch because the client had behaviors the last couple of days. The staff included bed wetting as one of the behaviors and not cleaning her room and refusing to take her medication and slamming the van doors. The staff also admitted to audio taping the client one time on the van as a joke. The staff indicated she told [client #5] that she could not get the iced coffee because the card had not been left out by the supervisor. The committee is substantiating abuse due to her using not going out to lunch as punishment which is not in the client's behavior plan. The committee is not understanding the purpose of the audio taping, but this should not have been done without the supervisor's permission. The staff appears to be engaging in 'power struggles' and this is not appropriate with our clients. The committee is recommending a written warning for the staff and close monitoring that this type of 'controlling' does not occur. We also recommend that she be re-trained on the behavior support plan."</p> <p>The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 9/24/13 at 3:57 P.M.. The policy indicated</p>			

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	<p>"Client safety is of utmost importance to the staff of Easter Seals Arc. Abuse and neglect of clients will not be tolerated...A.)...Abuse, neglect, exploitation, and mistreatment are expressly forbidden...Suspected instances of neglect, abuse, exploitation, client mistreatment or any infractions of this policy by staff must be reported to the Supervisor, Manager, or President immediately. This supervisor will then report the alleged violation(s) to the client's legal representative if applicable and to any other person according to BDDS regulations when applicable. Employees must report suspected or observed instances of neglect, abuse, or exploitation...."</p> <p>The RN was interviewed on 9/24/13 at 12:45 P.M. The RN indicated the behaviors usually occurred at times of transition, when the clients were riding on the van.</p> <p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:26 A.M. When asked about client #2's aggressive behavior, the ADSL stated, "We report it each time. Separate and counsel with him and the victim. We look for what might have caused the behavior and try to change the environment if we can. Yes, it is against</p>						

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	<p>our policy for a client to hit another client." The ADSL indicated staff had not followed client #5's plan and had used refusal for an outing as punishment which was not part of client #5's BSP.</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed to take appropriate corrective action to prevent ongoing client to client physical aggression involving 1 of 3 sampled clients (client #2) towards 2 of 3 sampled clients (clients #1 and #3) and 2 of 3 additional clients (clients #4 and #5).</p> <p>Findings include:</p> <p>The facility records were reviewed on 9/13/13 at 11:09 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 9/12/12 through 9/13/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 9/14/12 for an incident on 9/14/12 at 4:15 P.M. indicated "This afternoon [client #2] hit [client #3] in the midsection. Staff immediately separated [client #2] and [client #3]. [Client #3] was evaluated by staff for pain and injury. [Client #3] expressed no pain and no injury was found. In the future staff will monitor [client #3] and [client #2] more closely when they are in the same room." Despite the increased staff monitoring physical aggressive behaviors continued.</p>	W000157	<p>Group homestaff will be retrained on client #2's behavior support plan PersonResponsible: QIDPCompletionDate: October 24, 2013 Grouphome staff will be trained on abuse, neglect, and exploitation prevention PersonResponsible: QIDPCompletionDate: October 24, 2013 Ongoing,all staff will be trained on preventing abuse neglect and exploitation annually. PersonResponsible: Group home supervisorCompletionDate: October 24, 2013 Ongoing, toprevent further physical aggression, group home staff will have client #2 sitin the front seat and will load him into the van first. PersonResponsible: Group home supervisorCompletionDate: October 24, 2013</p>	10/24/2013			

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	<p>A BDDS report dated 12/7/12 for an incident on 12/6/12 at 3:30 P.M. indicated, "While the clients were on the van riding home from the day program, [Client #2] reportedly struck [client #5] on her face. Staff reports there were no visible triggers prior to the incident. [Client #5] appears to have suffered no injuries as a result of this incident. [Client #2] has a Behavior Support Plan (BSP) which addresses the targeted behavior of physical aggression. [Client #2] also has a Behavior Clinician (BC) who works with him on appropriate social behavior. [Client #2's] BC has been notified of this incident. [Client #2] has had 1 (one) other reported incident of physical abuse over the past year. Given this information, [client #2's] interdisciplinary team (IDT) does not feel that a change to his plan is needed at this time as his current BSP appears to be an effective tool at preventing acts of aggression with [client #2]. Should any future patterns of aggression develop, [client #2's] IDT will consider a needed change to his plan." Despite the IDT's review of client #2's BSP and his BC's intervention strategies client #2's physically aggressive behaviors continued.</p> <p>A BDDS report dated 2/1/13 for an incident on 1/31/13 at 3:20 P.M. indicated</p>			

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	<p>"...while both individuals were riding the group home van after day programming, [client #2] grew agitated and struck [client #4] on his forearm. [Client #4] appears to have suffered no apparent injury as a result of this incident. Staff was able to verbally redirect [client #2] after the incident. Thus preventing further escalation. [Client #2] has a BSP in place which addresses the targeted behavior or (sic) physical aggression. [Client #2] also has a BC who has been informed of this incident. Staff were unable to identify a possible trigger for the incident. [Client #2] has had 1 (one) other reported incident of physical aggression involving another client within the past 6 (six) months. At present time, no changes appear to be needed to both clients' plans as no patterns of aggression appear to exist." Despite client #2's BSP his aggressive behaviors towards his housemates continued.</p> <p>A BDDS report dated 4/29/13 for an incident on 4/26/13 at 7:15 A.M. indicated, While clients were riding the van to day program... "[Client #1] reportedly grew agitated and began yelling. This upset [client #2] who struck [client #1] on her arm in an effort to stop her from yelling out. [Client #1], in retaliation, struck [client #2] back on his arm. Staff were able to verbally redirect</p>			

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	<p>both clients before the situation was able to escalate further. Both clients have BSPs which address the targeted behavior of physical aggression. Neither client appears to have suffered any injuries as a result of these incidents. Both [client #2's] and [client #1's] BCs have been notified of this incident. [Client #2] had 1 (one) other reported incident of physical aggression in the last 6 (six) months. This was directed toward a different client. [Client #1] has not had any other reported incidents of physical aggression with another client in the last 1 (one) full year. At present time, no patterns of aggressive behavior appear to exist between both clients. No changes to both [client #1's] and [client #2's] plan appear to be needed at this time." Despite client #2's BSP and BC's intervention strategies client #2's aggressive behaviors continued.</p> <p>A BDDS report dated 5/16/13 for an incident on 5/15/13 at 4:15 P.M. indicated "While loading the van...[client #2] smacked [client #3] on her arm...[Client #3] did not develop any injuries as a result of this incident. [Client #2] has a BSP which addresses the targeted behavior of physical aggression. He has a BC who helps him in appropriate social behavior. [Client #2] has had 1(one) other incident of physical aggression toward another client within the last 6 (six)</p>			

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	<p>months. This incident involved a different client. Thus, no patterns of aggression are apparent at the present time with [client #2]. [Client #2's] BC has been notified of this incident. At the present time, no changes appear to be needed to [client #2's] plan." Despite client #2's BSP and BC's intervention strategies client #2's aggressive behaviors continued.</p> <p>A BDDS report dated 8/20/13 for an incident on 8/20/13 at 3:15 P.M. indicated "When [client #4] was getting into the van and sat down beside [client #2]. When [client #4] sat down besides (sic) [client #2] starting (sic) hitting him (client #4) in the shoulder and upper arm. Staff moved [client #4] away from [client #2] and counseled him not to hit [client #4] that he could have hurt him. [Client #2] apologized to [client #4] after talking with staff. Staff was present when the physical aggression took place. Staff will monitor [client #2] when he is the van (sic)."</p> <p>Despite the increased staff monitoring client #2's physical aggressive behaviors towards his housemates continued.</p> <p>The RN was interviewed on 9/24/13 at 12:45 P.M. The RN indicated the behaviors usually occurred at times of transition, when the clients were riding on the van.</p>			

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	<p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:26 A.M. When asked about client #2's aggressive behavior, the ADSL stated, "Usually it happens in the van. We even got a larger van for more space. He (client #2) is supposed to ride up front by the driver. We report it each time. Separate and counsel with him and the victim. We look for what might have caused the behavior and try to change the environment if we can. It has continued throughout the year."</p> <p>9-3-2(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation and interview, the facility failed to provide sufficient day program staff to provide active treatment and meet the individual needs for 2 of the 3 sampled clients (clients #1 and #3) who attended the class at the facility owned and operated day program.</p> <p>Findings include:</p> <p>Observations of the facility owned and operated adult day center (ADC) were conducted on 9/13/13 from 1:47 P.M. through 3:00 P.M. There were two staff present in the room. At 1:47 P.M. client #3 was seated at a table facing the wall with her left side towards the TV. An animated musical movie was playing on the TV. When music came on the TV client #3 would turn her head to the left to look at the TV. Client #3 had no activities on the table in front of her. Client #1 was seated in a recliner with a blanket over her which was pulled up to her chin. Client #1 had her eyes closed and her</p>	W000186	<p>In order to ensure adequate staff in client #1 and client #3's room at the adult day center, the director of the facility will complete a checklist to indicate that all staff are present. This checklist will be completed daily for one month and then weekly for two months. Person Responsible: Director of Adult Day Center Completion Date: October 24, 2013 The Adult Day Center staff will be trained on active treatment and rotating attention among clients. Person Responsible: Director of Adult Day Center Completion Date: October 24, 2013 Observations will be done by the supervising case worker once per week, Director of Adult Day Center once per month for 3 months. Observers will check to ensure that active treatment is taking place. Person Responsible: Director of Adult Day Center Completion Date: October, 24 2013</p>	10/24/2013
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	<p>head tilted to the right against the back of the chair. At 2:20 P.M. Day Program Staff (DPS) #2 entered the class room and talked with client #1 and then talked with client #3, offering client #3 a stack of building blocks to stack. Client #3 touched the already stacked blocks and pushed them away from her. Client #3 was offered an electronic game which she forcefully pushed away from her. Client #1 remained seated in the recliner with her eyes closed. At 2:27 P.M. client #1 was asked to come to the table where client #3 was seated. Client #1 sat at the table. She was offered the electronic game and pushed it away from her stating "I'm afraid of it." At 2:28 P.M. client #1 and client #3 were each given a glass of orange juice and a small bag of gold fish shaped crackers. Client #1 and client #3 ate their snack with their fingers. The three staff, DPS #2, DPS #3 and DPS #4, who were in the room did not prompt or encourage client #1 or client #3 to wash their hands prior to eating their snack. Clients #1 and #3 were not offered a choice of snack, or asked to participate in the snack time activities of getting the snack themselves or throwing away their own trash. At 2:36 P.M. two peers in the class room began to have behavior needs. DPS #1 removed peer A from the room to assist him. Peer B required the assistance of DPS #2, DPS #3, and DPS #4. During</p>			

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	<p>this time period client #3 sat at the table without activity. Client #3 sat in the recliner with a blanket and closed her eyes. Peer B returned to activity at 2:49 P.M. and Peer A and DPS #1 returned to the class room at 2:53 P.M.</p> <p>Day Program Staff (DPS) #1 was interviewed on 9/13/13 at 2:54 P.M. DPS #1 stated, "We have been working a little short. [Peer B] is a handful. He almost needs one-on-one supervision for his own safety and for the others in the class room. We cannot meet their needs when we have to spend so much time with him (peer B)."</p> <p>DPS #3 was interviewed on 9/13/13 at 2:51 P.M. DPS #3 stated, "Yes, I am filling in for someone who called off today. [DPS #2] was due off 15 (fifteen) minutes ago. There are usually four people in here. [Peer B] really needs one-on-one staffing. He will put anything he can find into his mouth. We have to hide everything from him. He grabs the other clients' food and drinks."</p> <p>The Director of the ADC (DADC) was interviewed on 9/24/13 at 11:28 A.M. The DADC stated, "We have been down staff. We have had to move some clients around. It has been kind of a rough month. As of 9/30/13 we will be fully</p>			

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	<p>staffed again. The other day we had temporary staff helping. All month we have been working short and have had to call temp (temporary) staff in."</p> <p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:18 A.M. and stated, "There should always be adequate staffing."</p> <p>9-3-3(a)</p>			

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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, the facility failed to provide continuous active treatment at all formal and informal opportunities for 2 of the 3 sampled clients (clients #1 and #3) at the facility owned and operated day program.</p> <p>Findings include:</p> <p>Observations of the facility owned and operated adult day center (ADC) were conducted on 9/13/13 from 1:47 P.M. through 3:00 P.M. At 1:47 P.M. client #3 was seated at a table facing the wall with her left side towards the TV. An animated musical movie was playing on the TV. When music came on the TV client #3 would turn her head to the left to look at the TV. Client #3 had no activities on the table in front of her. Client #1 was seated in a recliner with a blanket over her which was pulled up to her chin. Client #1 had her eyes closed and her head tilted to the right against the back of the chair. At 2:20 P.M. Day Program Staff (DPS) #2 entered the class room and talked with client #1</p>	W000249	<p>TheAdult Day Center staff will be trained on active treatment and rotatingattention among clients PersonResponsible: Director of Adult DayCenterCompletionDate: October 24, 2013 Observationswill be done by the supervising case worker once per week and Director of AdultDay Center once per month for 3 months. Observers will check to ensure that active treatment is taking place PersonResponsible: Director of Adult DayCenterCompletionDate: October 24, 2013</p>	10/24/2013			

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	<p>and then talked with client #3, offering client #3 a stack of building blocks to stack. Client #3 touched the already stacked blocks and pushed them away from her. Client #3 was offered an electronic game which she forcefully pushed away from her. Client #1 remained seated in the recliner with her eyes closed. At 2:27 P.M. client #1 was asked to come to the table where client #3 was seated. Client #1 sat at the table. She was offered the electronic game and pushed it away from her stating "I'm afraid of it." At 2:28 P.M. client #1 and client #3 were each given a glass of orange juice and a small bag of gold fish shaped crackers. Client #1 and client #3 ate their snack with their fingers. The staff in the room, DPS #2, DPS #3 and DPS #4, did not prompt or encourage client #1 or client #3 to wash their hands prior to eating their snack. Clients #1 and #3 were not offered a choice of snack, or asked to participate in the snack time activities of getting the snack themselves or throwing away their own trash. At 2:36 P.M. two peers in the class room began to have behavior needs. DPS #1 removed peer A from the room to assist him. Peer B required the assistance of DPS #2, DPS #3, and DPS #4. During this time period client #3 sat at the table without activity. Client #3 sat in the recliner with a blanket and closed her eyes. Peer B returned to</p>			

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	<p>activity at 2:49 P.M. and Peer A and DPS #1 returned to the class room at 2:53 P.M.</p> <p>Client #1's record was reviewed on 9/16/13 at 10:05 A.M. Client #1's record indicated she had an Individual Support Plan (ISP) dated 11/21/12 which included the following day program goals: participate in ADC all week, participate in scheduled recreational outings to increase social behavior and use a math workbook to increase money management skills.</p> <p>Client #3's record was reviewed on 9/16/13 at 12:01 P.M. Client #3's record indicated she had an ISP dated 11/29/12 which included the following day program goals: attend ADC each day, participate in scheduled recreational outings to increase social behavior, gross motor activities requiring standing 10-15 (ten to fifteen) minutes daily and participate in music related activity for 10-15 minutes daily.</p> <p>Day Program Staff (DPS) #1 was interviewed on 9/13/13 at 2:54 P.M. DPS #1 stated, "We have been working a little short. [Peer B] is a handful. He almost needs one-on-one supervision for his own safety and for the others in the class room. We cannot meet their needs when we have to spend so much time with him (peer B)."</p>			

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	<p>The Director of the ADC (DADC) was interviewed on 9/24/13 at 11:28 A.M. The DADC indicated clients #1 and #3 should have been involved in more activities. The DADC stated, "Staff should be trying to involve them in some activity, even if the client needs lots of encouragement to not sleep."</p> <p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:18 A.M. and stated, "They are to be working on meaningful activities at all times."</p> <p>9-3-4(a)</p>			

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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. Based on record review and interview, the facility failed to assure all medications were administered according to the physician's orders for 2 of 3 sampled clients (clients #1 and #2) and for 2 of 3 additional clients (clients #4 and #5).</p> <p>Findings include:</p> <p>The facility records were reviewed on 9/13/13 at 11:09 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 9/12/12 through 9/13/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 2/13/13 for an incident on 2/10/13 at 6:00 A.M. indicated "The doctor performing the colonoscopy had ordered [client #4's] daily multivitamin (supplement) to be held from 2/10/13 until 2/15/13. The Easter Seals nurse for [client #4] sent instructions to hold the medication to [client #4's] group home. On 2/12/13 it was discovered that the group home supervisor had not written 'hold' on the medication administration record (MAR), so the medication was still given 2/10, 2/11, and 2/12...."</p>	W000368	<p>Nurses are responsible to ensure that all new medication orders are properly begun PersonResponsible: Nursing supervisorCompletionDate: October 24, 2013 Ongoing, to ensure that all new medication orders begin, the nursing caseloads will be assigned to other nurses when the regular nurse is on vacation PersonResponsible: Nursing supervisorCompletionDate: October 24, 2013 Ongoing, to ensure that all staff are following the medication policies, the group home supervisor will observe each staff person pass medications once every three months. PersonResponsible: Group home supervisorCompletionDate: October 24, 2013</p>	10/24/2013	

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	<p>A BDDS report dated 4/6/13 for an incident on 4/4/13 at 6:00 P.M. indicated "...He (client #2) receives Vimpat (anti-seizure medication) 50mg (milligrams) three times a day and Vimpat 100mg at bedtime for seizure control. He also receives Diazepam (anti-anxiety) 2mg twice a day at 6:00 A.M. and 10:00 A.M. and Diazepam 1mg twice a day at 2:00 P.M. and 6:00 P.M. for seizure control. On 4/4/13 his (client #2's) 6:00 P.M. dose of Vimpat 50mg and Diazepam 1mg were not given. Staff passing the medications on 4/5/13 at 6:00 P.M. observed the medications still in the bubble packs. [Client #2] did not appear to have any side effects, and had no increased seizure activity...."</p> <p>A BDDS report dated 4/11/13 for an incident on 4/10/13 at 6:00 A.M. indicated "[Client #5] went to her psychiatrist on 4/8/13 and had medication changes...ordered her Sertraline (anti-depressant) 100mg tablet be reduced for two weeks to 50mg, then stopped. He also ordered her a new medication Pristiq (anti-depressant) 50mg be started at the same time the Sertraline was being decreased. The medication was ordered from the pharmacy and sent to the nursing office. The medication was not to be started until the guardian approved the</p>			

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	<p>medications, so the changes had not been made to the MAR and instructions to start the medications had not been given by the nursing staff. An email had been sent to the supervisor and home staff instructing them to not start the medications until approval had been given by the Qualified Intellectual Disabilities Professional (QIDP). The medications were sent home with staff on the evening of 4/9/13, with approval still pending. The morning staff gave the medications even though they were not on the MAR, and there were no instructions to give. This resulted in [client #5] receiving both the old dose of Sertraline (100mg) and the new dose of Sertraline (50mg) for a total of 150mg. This also resulted in her receiving the Pristiq 50mg without guardian approval... [client #5] does not appear to have had any side effects."</p> <p>A BDDS report dated 6/26/13 for an incident on 6/19/13 at 8:00 P.M. indicated "[Client #2] receives Vimpat (seizures) 50mg four times a day for seizures, with the 8:00 P.M. dose being two tabs. (tablets), for a total of 100mg. He went to the doctor's appointment on 6/19/13 with his father. He received a new order for an increase in Vimpat, to three tabs. at 8:00 P.M., for a total of 150mg. The physician sent the prescription to the pharmacy. The pharmacy did not send any more</p>			

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	<p>medication to the home, expecting the staff to give additional pills from the bubble packs [client #2] had. The nurses did not notify the home of the change because normally the pharmacy sends additional bubble packs, and sends a change to the electronic medication administration system (EMAR). The pharmacy also sends a copy of the electronic order they receive to the agency nurse to notify Easter Seals of changes. This did not happen. [Client #2] did not receive his increased dose until 6/25/13 when it was discovered by the agency nurse that the medication had never been sent to the home and the EMAR had not been changed."</p> <p>A BDDS report dated 8/12/13 for an incident on 8/10/13 at 10:00 A.M. indicated "[Client #2] was given an extra dose of Valium (anti-anxiety for seizure control) and did not receive his Vimpat (seizure) medication. Nurse was notified and staff monitored [client #2] through out the night."</p> <p>A BDDS report dated 8/12/13 for an incident on 8/10/13 at 8:30 P.M. indicated "[Client #1] received two dosaes (sic) of the following medication; Clozapine (anti-anxiety), Cerozine (sic) (unknown), and Calcium (supplement). Nurse was notified and [client #1] was monitored</p>			

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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
	<p>through out the night for side effects of extra medication."</p> <p>The Residential Manager (RM) was interviewed on 9/16/13 at 8:40 A.M. and indicated one of the medication errors had been her failing to write "hold" on the MAR.</p> <p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:26 A.M. The ADSL indicated there had been several medication errors in the past year. The ADSL stated, "Some of them happened at medication exchange." The ADSL indicated clients should always get their medications according to what their physician prescribed for them.</p> <p>The RN was interviewed on 9/24/13 at 12:45 P.M. The RN stated, "Several of the medication errors occurred around the eleventh of the month. The eleventh of each month is our medication exchange day. I check in all of the medications for my houses, and make any needed notations, making sure all the medications have been delivered and are correct. If the eleventh day of the month falls on a weekend we send the medications to the homes. The staff all know they are not to start the new cards until the 4:00 P.M. medication pass on the eleventh day of</p>			

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	the month, but they get confused somehow." 9-3-6(a)			

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W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed to implement and encourage hand washing prior to providing 2 of 3 sampled clients (clients #1 and #3) their snack in the adult day center (ADC).</p> <p>Findings include:</p> <p>Observations of the facility owned and operated adult day center (ADC) were conducted on 9/13/13 from 1:47 P.M. through 3:00 P.M. Client #1 and client #3 touched activity materials and items in the class which had also been touched by peers in the class room. At 2:28 P.M. client #1 and client #3 were each given a glass of orange juice and a small bag of gold fish shaped crackers. Client #1 and client #3 ate their snack with their fingers. Day program staff (DPS) #2, DPS #3 and DPS #4 did not prompt or encourage client #1 or client #3 to wash their hands prior to eating their snack.</p> <p>Day Program Staff (DPS) #1 was interviewed on 9/13/13 at 2:54 P.M. DPS #1 indicated clients #1 and #3 should have washed their hands prior to eating their snack.</p>	W000455	<p>TheAdult Day Center staff will be retrained on infection control including washinghands prior to eating PersonResponsible: Director of Adult DayCenterCompletionDate: October 24, 2013 Observationswill be done by the supervising case worker once per week, Director of AdultDay Center once per month for 3 months. Observers will check to ensure that infection control procedures arebeing followed PersonResponsible: Director of Adult DayCenterCompletionDate: October 24, 2013</p>	10/24/2013			

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	<p>The Director of the ADC (DADC) was interviewed on 9/24/13 at 11:28 A.M. When asked if the clients should wash their hands prior to snack, the DADC stated, "I think they should wash their hands."</p> <p>The Assistant Director of Supported Living (ADSL) was interviewed on 9/24/13 at 10:18 A.M. and indicated clients should wash their hands prior to eating.</p> <p>The RN was interviewed on 9/24/13 at 12:25 P.M. The RN indicated hand washing should occur prior to eating.</p> <p>9-3-7(a)</p>			