

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/15/2012
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 5924 ABBOTT ST FORT WAYNE, IN 46816
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 8, 9, 13, 14 and 15, 2012.</p> <p>Facility Number: 000618 Provider Number: 15G074 AIMS Number: 100233730</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 20, 2012 by Dotty Walton, 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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W0149	<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 neglected to follow their policy for the prevention of abuse and neglect for 1 of 4 sampled clients (client #2), by using a chemical hair remover which caused client #2 to have bodily injury/chemical burns; as indicated in 1 of 39 Bureau of Developmental Disabilities Services reports reviewed.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/8/12 at 1:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/8/11 until 11/8/12. The BDDS reports indicated:</p> <p>A BDDS report dated 5/7/12 for 5/7/12 at 9:40 A.M. indicated, "...It was reported by [client #2] at the day service staff that weekend staff at the group home had applied [name of hair removal lotion] to her groin area to remove unwanted hair. In doing so [client #2] had incurred apparent chemical burns and open sores approximately 1" (one inch) in length around her groin area. [Client #2] has been seen by her primary care physician (PCP) and has been ordered to stay at</p>	W0149	<p><u>W149</u></p> <p>The facility has policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Current house staff and all new hired house staff will be in-serviced about the use of chemical products. Staff will be instructed to not use products such as Nair, without prior authorization or training, as applicable, from the residential supervisor or agency RN.</p> <p>Person Responsible: Residential Supervisor Completion Date: December 15, 2012</p>	12/15/2012			

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	<p>home for the remainder of the week to help in the healing process. [Client #2] will also see her PCP on 5/11/12 for a follow-up. Staff has been suspended pending the outcome of an investigation...."</p> <p>A follow-up BDDS report dated 5/11/12 indicated, "The investigation revealed that although the staff person involved did admit to using the product on [client #2's] groin area it was out of concern for the risks imposed from shaving her. Staff was apparently concerned over the possibility that she may scratch [client #2] while shaving the area. [Client #2] had requested for the hair to be removed. However the staff did not test the product on any part of [client #2's] groin area 24 (twenty-four) hours earlier as directed on the instructions section located on the back of the [name of hair removal lotion] bottle. The staff person involved [name] is to be disciplined according to agency policy based on the results of the investigation. [Client #2's] follow-up with her PCP presented another doctor (sic) order for [client #2] to stay home an additional week. [Client #2] is also to have gauze dressing applied daily by the group home staff to help in the healing process...."</p> <p>A follow-up BDDS report dated 5/21/12</p>			

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	<p>indicated, "...[client #2's] open sores appear to be healing and she will continue to have medical ointment and gauze applied daily to help continue the healing process...GH staff have been informed that chemical hair removal products are not to be used...."</p> <p>A review of the facility internal investigation documentation dated May 6, 2012 was completed on 11/14/12 at 1:35 P.M.. The investigation summary indicated, "...staff did not follow the instructions by testing the product...she did not appropriately report the possible injury properly, and the result was injuries to the client... pretty deep burns. The abuse is substantiated...." The nursing statement dated 5/7/12 indicated "...I (RN) took [client #2] into changing room where [client #2] pulled down her pants and revealed pubic area that was hairless and numerous open sores were noted in her groin and around her rectum, while in changing room [client #2] said staff had put [name of hair removal lotion] on her."</p> <p>The facility Standard Operating Procedure/Abuse and Neglect Policy revision date 5/07 was reviewed on 11/8/12 at 11:40 A.M.. The policy indicated "A.)...Abuse, neglect, exploitation, and mistreatment are expressly forbidden...Suspected instances</p>			

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	<p>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>An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/15/12 at 9:45 A.M.. The QDDP stated, "The incident did happen, it was substantiated and disciplinary action was given."</p> <p>An interview was conducted with the nursing supervisor (NS) on 11/15/12 at 10:40 A.M.. The NS stated, "They were doing a spa day at the home and [client #2] had requested the hair to be removed. [Client #2] had open sores and a prescription dressing was ordered by her PCP."</p> <p>An interview was conducted with the facility Quality Assurance Director (QAD) on 11/14/12 at 1:25 P.M.. The QAD stated, "It was substantiated as abuse." The QAD indicated the facility</p>			

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	abuse policy had not been followed by the group home staff. 9-3-2(a)				

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W0340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on record review and interview, facility nursing and other members of the interdisciplinary team failed to take appropriate health measures, including but not limited to training, 1 additional client (#5) on the importance of taking medications as ordered by his physician during therapeutic leaves with his family.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/8/12 at 1:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/8/11 until 11/8/12. The BDDS reports indicated:</p> <p>A BDDS report dated 9/24/12 for 9/22/12 at 6:00 A.M. indicated "...He (client #5) returned home on the evening of Sunday September 23 rd. It was discovered by staff that he still had his medications for Sunday morning in his bubble packs that were sent to his father's house. These medications included clonazepam (benzodiazepine to calm nerves) 0.25 mg (milligrams) twice a day for behaviors,</p>	W0340	<p>W340</p> <p>Agency nurse will train client on the importance of taking his medications while on therapeutic leave. Agency nurse will teach him about the potential health risks of not taking his medicine as prescribed while on theraputic leave.</p> <p>QIDP had a face-to-face meeting with client's father, on 11/29/12. Client's father indicated he will set his alarm to remind him it is time to give client his medications.</p> <p>QIDP will implement an objective to train client to self-initiate his medication administration by alerting the staff that it's time for his medications.</p> <p>Residential staff will continue to circle the pills on the bubble packs that dad is to be giving as there has been some improvement with this system in place. Residential supervisor will monitor and train new staff ongoing about this practice.</p> <p>Person Responsible: Agency RN, QIDP, Residential Supervisor</p>	12/15/2012			

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	<p>hydrochlorothiazide (diuretic) 12.5 mg for hypertension, sertraline hcl (anti-depressant) 100 mg twice a day for depression, and thioridazine (anti-psychotic) 100 mg for anxiety. He also missed his morning dose of clonazepam 0.25 mg on Saturday morning...Staff were already marking which pills needed to be given while at home, and sending a copy of his medication administration records. Staff will continue to remind [name of client #5's father] to give [client #5] his medications on time."</p> <p>A BDDS report dated 7/9/12 for 7/8/12 at 8:00 P.M. indicated "...Agency nursing staff reports having discovered that while [client #5] had been on a therapeutic home visit with his family this past weekend, he had missed the following medications at the prescribed times; Sertraline 100 mg AM dose, was not administered on 7/8/12; Clozaril (anti-psychotic) 0.25 mg AM dose was not administered on 7/6/12 (sic); Thioridazine 100 mg AM dose was not administered on 7/8/12; and Hydrochlorothiazide 12.5 mg AM dose was not administered on 7/8/12...[Client #5's] IDT (interdisciplinary team) will inform his family of the missed medications and will stress the importance of giving the medications to</p>		Completion Date: December 15, 2012		

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	<p>[client #5] at the prescribed time."</p> <p>A follow-up BDDS report dated 7/16/12 indicated "[Client #5's] IDT does feel the med (medication) errors which have occurred while he has been on therapeutic home visits are a problem, but are not considered neglectful. [Client #5's] family have been informed of the importance of insuring [client #5] is given his medications as prescribed at all times for the benefit of [client #5] as well as the family...."</p> <p>A BDDS report dated 5/14/12 for 5/13/12 at 4:00 P.M. indicated "...Residential nursing staff reports that while [client #5] was on therapeutic home visit, his scheduled doses of Clozaril and Mellaril (anti-psychotics) were not given...."</p> <p>A BDDS report dated 1/30/12 for 1/29/12 at 6:00 A.M. indicated "...He (client #5) is prescribed Klonopin (benzodiazepine to calm nerves) 0.25 mg twice a day. He did not receive his 6:00 A.M. dose while with his father Sunday morning. Father denies not giving the medication, but the pill was still in the package when [client #5] returned. The father already receives a MAR that is sent along with the medications...Staff will write the date next to the pill in the package in an effort to show father which pills are to be</p>			

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	<p>given."</p> <p>A BDDS report dated 1/2/12 for 12/31/12 at 6:00 A.M. indicated "...Agency nursing staff reports that [client #5] has had two separate occasions of missed medications over the past week, both occurring while on therapeutic home visits with his family for the holidays. On 12/25/11 [client #5] did not receive his 6:00 A.M. doses of Klonopin and Mellaril. Nursing staff has left a message with [client #5's] psychiatrist to inform him of this issue on 1/02/2012. On 12/31/11 [client #5] did not receive his 6:00 A.M. dose of Hydrochlorothiazide. This is a blood pressure medication. A message was left with [client #5's] primary care physician....The QMRP (qualified mental retardation professional) has contacted [client #5's] father to inform him of the missed medications and also stressed to him the importance of having [client #5] receive all prescribed medications at the appropriate date and time while [client #5] is on home visits. [Name of father] assured QMRP that he would be more careful in the future when administering [client #5's] medications while he is home visiting...."</p> <p>Client #5's record was reviewed on 11/14/12 at 10:12 A.M. client #5's Individual Support Plan (ISP) dated</p>			

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	<p>11/2011 indicated he had a medication goal to "State the side effects of one of his medications." Client #5's ISP did not include a plan or training goal to assist him with compliance with his physician's orders in taking his medications when he is on home visits with his family</p> <p>Client #5 was interviewed on 11/13/12 at 7:50 A.M. Client #5 stated, "When I take my meds (medication) they report it to the nurse if I miss them. I feel better when I take them. What are the rules about pills? Take them as the doctor ordered them?"</p> <p>An interview was conducted with direct care staff (DCS) #1 on 11/13/12 at 7:45 A.M. DCS #1 stated, "You can usually tell when he (client #5) hasn't had his medications. He paces back and forth and will have trouble sleeping."</p> <p>An interview was conducted with the residential supervisor (RS) on 11/14/12 at 5:07 P.M.. The RS stated, "We circle the pills in the bubble packs. We have seen some improvement, but it still happens." The RS indicated client #5 did not have a goal or program to learn to take his medications when on his home visits.</p> <p>An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/15/12 at 9:45</p>						

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	<p>A.M.. The QDDP stated, "I called his (client #5's) dad. He apologized to me. I told him the state ensures his physician's orders are followed when they come in for survey. Staff are marking the cards. His (client #5's) stepmother is ill, they have a lot going on at their house and I don't want to restrict his (client #5's) home visits. I think dad just forgets."</p> <p>An interview was conducted with the nursing supervisor (NS) on 11/15/12 at 10:40 A.M.. The NS stated, "The previous supervisor started having the staff date and write 'dad' next to the pill and send a copy of the MAR. The errors still continued even with the marking of the pills. Staff has talked with his dad."</p> <p>9-3-6(a)</p>			

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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 order for 2 of 4 sampled clients (#1 and #2) and 2 additional clients (#6 and #7).</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/8/12 at 1:40 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/8/11 until 11/8/12. The BDDS reports indicated:</p> <p>A BDDS report dated 8/31/12 for 8/29/12 at 8:00 P.M. indicated "...staff came into nursing office to pick up new chlorhexidine (oral rinse), stating she did not have enough for her (client #1's) morning dose. She (client #1) was given that dose in the nursing office and staff took the new bottle home. When [client #1's] nurse was going through her email that day, it was discovered the night staff had emailed her nurse the night before, stating there was no rinse to be given, and she did not give it. Staff did not follow protocol to let nursing staff know there was no rinse left, as more rinse was</p>	W0368	<p><u>W368</u></p> <p>The facility has policies and procedures to ensure all medications are administered in compliance with the physician's orders.</p> <p>Residential supervisor will complete a supervised medication pass on all residential DSP's at this group home and quarterly on-going to ensure all medications are administered in compliance with physician orders.</p> <p>Person Responsible: Residential Supervisor Completion Date: December 15, 2012</p>	12/15/2012			

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	<p>available for pick up. [Client #1's] dentist was notified, with no new orders. No adverse effects were noted." The BDDS report indicated client #1 missed her oral rinse on the night of 8/29/12 and received the 8/30/12 morning dose late.</p> <p>A BDDS report dated 2/21/12 for 12/3/12 at 6:00 A.M. indicated, "...She [client #1] receives caltrate 600 + D orally twice a day (calcium with vitamin D). The staff on the mornings of 2/3/12 to 2/8/12 did not administer this medication. Her physician has been notified. [Client #1] has had no observable adverse effects from this. Staff have been reinserviced on when to call the nurse about a medication omission. The medication error policy was followed up to (sic) and including termination of staff where necessary." The BDDS report indicated client #1 missed her Caltrate on the mornings of 2/3/2012, 2/4/2012, 2/5/2012, 2/6/2012, 2/7/2012 and 2/8/2012.</p> <p>A BDDS report dated 1/24/12 for 1/22/12 at 8:00 P.M. indicated, "...She [client #2] was prescribed Prednisone (steroid)...40 mg (milligrams) for three days, 20 mg for three days, and 10 mg for three days with no specific time. The pharmacy delivered a bottle of medication at 5:00 A.M. on 1/22/12. The nursing supervisor went to</p>			

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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 5924 ABBOTT ST FORT WAYNE, IN 46816
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	<p>the home and wrote the MAR (medication administration record) separating the medication into four doses for the three days, 10 mg at each dose. The staff administered this correctly at 6:00 A.M., 12:00 P.M., and 4:00 P.M. on 1/22/12. Before the 8:00 P.M. dose the pharmacy sent a new blister pack with once a day dosing of 40 mg in one pack. The 8 P.M. staff incorrectly gave the 40 mg that came from the pharmacy. This caused [client #2] to receive 70 mg instead of the prescribed 40 mg on 1/22/12. On 1/23/12 staff brought in the blister pack explaining the pharmacy sent extra medication. When the nursing supervisor saw there was extra medication at the home, the nursing supervisor went to the home at 4:00 P.M., discovering the extra mg (sic) that had been given. The physician was notified. He instructed the nurses to give the regular 40 mg dose on 1/23/12 and continue the rest of the administration of the medication as prescribed. He stated that the extra 30 mg would not cause any undesirable side effects. The nursing supervisor who wrote the medication realizes that the way she wrote the mediation out led to the error. The pharmacy sending extra medication also led to the error...." The BDDS report indicated client #2 was given an extra 40 mg of prednisone.</p>			

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	<p>A BDDS report dated 1/24/12 for 1/22/12 at 8:00 P.M. indicated, "...He (client #6) was prescribed prednisone. The physician prescribed 30 mg for three days, 20 mg for three days, and 10 mg for three days with no specific time. The pharmacy delivered a bottle of medication at 3:00 A.M. on 1/22/12. The nursing supervisor went to the home and wrote the MAR separating the medication into three doses for the first three days, 10 mg at each dose. The staff administered this correctly at 6:00 A.M. and 12:00 P.M. on 1/22/12. Before the 8:00 P.M. dose the pharmacy sent a new blister pack with once a day dosing of 30 mg in one pack. The 8 P.M. staff incorrectly gave the 30 mg that came from the pharmacy. This caused [client #6] to receive 50 mg instead of the prescribed 30 mg on 1/22/12. On 1/23/12 staff brought in the blister pack explaining the pharmacy sent extra medication. When the nursing supervisor saw there was extra medication at the home, the nursing supervisor went to the home at 4:00 P.M., discovering the extra mg (sic) that had been given. The physician was notified. He instructed the nurses to hold the regular dose on 1/23/12 and continue the rest of the administration of the medication as prescribed. He stated that the extra 20 mg would not cause any undesirable side effects.</p> <p>The nursing supervisor who wrote the</p>			

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	<p>medication realizes that the way she wrote the mediation out led to the error. The pharmacy sending extra medication also led to the error..." The BDDS report indicated client #6 received an extra 20 mg of prednisone.</p> <p>A BDDS report dated 2/21/12 for 2/16/12 at 6:00 P.M. indicated, "...He (client #7) had seen his family physician and was being treated for athlete's foot. He was to receive Tolnafate 1% powder (anti-fungal powder) to affected foot areas until healed. He did not receive this medication on 2/16/2012 and 2/17/2012. This was discovered by the nurse while checking records in the group home on 2/20/12. Staff were reinserviced on the importance of checking the MARs routinely and reporting med (medication) omissions...." The BDDS report indicated client #7 had not received his medication for athlete's foot for two days.</p> <p>A BDDS report dated 2/27/12 for 2/21/12 at 6:00 A.M. indicated, "...He (client #7) was prescribed Terbafine HCL 1% cream (anti-fungal cream) topically to feet once a day for 2 (two) weeks, for athlete's foot ending 2/9/12. He was reassessed, and his physician prescribed the medication, to start on 2/21/2012. It was not started until 2/24/12, then it was not given by staff on 2/25/12, and then given again on 2/26/12</p>						

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	<p>and 2/27/12. it was brought to the on call nurse's attention this morning, 2/27/12, that it had not been given as directed...." The BDDS report indicated client #7 received his medication for athlete's foot but it was not started for three days after his physician had ordered it, and staff failed to give it on another day.</p> <p>An interview was conducted with the residential supervisor (RS) on 11/14/12 at 5:07 P.M.. The RS stated, "We have had some medication errors, but it has been getting better."</p> <p>An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/15/12 at 9:45 A.M.. The QDDP stated, "There have been an excessive amount of medication errors. We have been proactive and taken corrective action after each circumstance."</p> <p>An interview was conducted with the Nursing Supervisor (NS) on 11/15/12 at 10:40 A.M.. The NS stated, "The pharmacy sent extra medication packaged in two different ways when the errors occurred for [client #2] and [client #6]. When the foot cream errors occurred for (client #7) we were switching to an electronic medication record (EMAR) the supervisors were to have the staff only</p>			

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	<p>use the EMAR, but they were still using the paper MAR and the paper MAR did not have the current order written on it, because the supervisor had not written it on the paper MAR."</p> <p>9-3-6(a)</p>			