

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G330	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 GLENMARY DR FORT WAYNE, IN46806
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 14, 15, 16, 17, 18, and 21, 2011.</p> <p>Facility number: 000848 Provider number: 15G330 AIM number: 100239610</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/Team Leader Kathy Wanner, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, for 5 of 5 clients (clients #1, #2, #3, #4 and #5) who resided in the home, the governing body failed to exercise operating direction over the group home to ensure maintenance/repair needs were addressed.</p> <p>Findings include:</p>	W0104	<p>The grout will be replaced, door will be painted and vent will be painted or replaced. Staff persons will be trained to notify the supervisor of any maintenance issues so that they can be corrected. Maintenance staff persons will perform a preventative maintenance check of the house monthly and will note and repair</p>	12/21/2011

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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W0153	<p>The group home where clients #1, #2, #3, #4 and #5 resided was observed on 11/14/11 from 5:15 A.M. until 8:05 A.M. In the small bathroom, next to the kitchen, the tile floor had areas where the grout between the tiles was missing. The back of the bathroom door had areas where the paint was worn off. The heater vent next to the commode was rusty.</p> <p>An interview was conducted with Direct Care Staff (DCS) #3 at 6:02 A.M. on 11/14/11. DCS #3 indicated the floor and vent had been "in need of repair for a while."</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:08 P.M. When asked about the repairs which needed to be completed to the group home bathroom the MRS stated, "They should be repaired."</p> <p>9-3-1(a)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p>	W0153	<p>any maintenance issues found during the inspections. Supervisory and Management staff will conduct observations on the following schedule: Supervisor once per week, QIDP once per month and Director of Residential Services once per month for three months. Work orders will be submitted for any maintenance issues found during these observations so they can be corrected.</p> <p>Person Responsible: Maintenance Supervisor and Director of Residential Services</p> <p>The injury of unknown origin was</p>	12/21/2011	

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	<p>Based on record review and interview, for 1 of 5 Bureau of Developmental Disabilities Services (BDDS) reports, the facility failed to immediately report client #5's unknown injury in accordance with State Law.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/14/11 at 10:30 A.M. including the BDDS reports for the time period between 11/14/10 and 11/14/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 2/16/11 for an incident on 2/12/11 at 1pm, indicated client #5 was assisted by facility staff with his grooming, "a half dollar sized bruise was discovered on his upper inner left arm. [Client #5] is unable to communicate how he may have gotten the bruise, so it is deemed to be unknown in origin." There was no indication why the incident had not been reported immediately to BDDS.</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:10 P.M. The MRS indicated she was unaware the reports had been submitted late.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>reported to the Supervisor. However, the Supervisor failed to follow agency procedures and report it to the QIDP immediately. The Supervisor was given disciplinary action for not following the procedure. Staff persons will be retrained on following procedures on immediate reporting of any injuries of unknown origin. Staff persons will be trained prior to working with clients and annually thereafter. The agency will take disciplinary action if an employee fails to adhere to the policy. Person Responsible: Director of Residential Services</p>		

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W0249	<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 ensure 3 of 3 sampled clients (clients #1, #2 and #3) received training consistent with their current Individual Support Plans (ISP).</p> <p>Findings include:</p> <p>Observations were conducted at the group home where clients #1, #2 and #3 resided on 11/14/11 from 5:15 A.M. until 8:05 A.M. including the following observations of morning medication administration:</p> <p>At 6:16 A.M. client #3 was observed to receive his morning medications from direct care staff (DCS) #2. Client #3 was observed to wash his hands, listen to the staff as she named each medication for him and why he was taking his medication. DCS #2 then poured client #3's glass of water and mixed it with one of his medications. DCS #2 asked client #3 to help stir the water and medication,</p>	W0249	<p>Staff persons will be re-inserviced on implementing clients' objectives during all formal and informal training opportunities. This will include objectives regarding self-administration of medication.</p> <p>Observations will be done by the Residential Supervisor once per week, the QIDP once per month and the Director of Residential Services once per month for 3 months. Observers will check to ensure that training objectives are implemented as written.</p> <p>Person Responsible: Director of Residential Services</p>	12/21/2011	

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	<p>which he did. Client #3 then drank the water/medication and threw his cup in the trash can. Client #3 did not pour his own water, nor was he asked to pour his own water.</p> <p>At 6:23 A.M. client #2 was observed to wash his hands, listen to the staff as she named each medication for him and why he was taking his medication. DCS #2 then poured client #2's glass of water mixed with one of his medications and client #2 drank the water/medication. DCS #2 then poured a second glass of water and asked client #2 to drink it. Client #2 drank the water and threw his cup in the trash can. Client #2 did not pour his own water, nor was he asked to pour his own water. No milk was observed offered or encouraged.</p> <p>At 6:37 A.M. client #1 was observed to wash his hands, listen to the staff as she named each medication for him and why he was taking his medication. Client #1 shook his head "yes" after DCS #2 named each medication. DCS #2 then poured client #1's glass of water mixed with one of his medications and client #1 drank the water/medication. DCS #2 then poured a second glass of water and asked client #1 to drink it. Client #1 drank the water and threw his cup in the trash can. Client #1 did not pour his own water, nor was he</p>				

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	<p>asked to pour his own water.</p> <p>Client #3's record was reviewed on 11/15/11 at 10:45 A.M. Client #3's record indicated he had an ISP dated 1/6/11. Client #3's ISP included a self administration of medication goal to "pour his own water while taking his medications."</p> <p>Client #2's record was reviewed on 11/15/11 at 11:15 A.M. Client #2's record indicated he had an ISP dated 4/27/11. Client #2's ISP included a self administration of medication goal to "pour his milk into a glass," (when taking his medications).</p> <p>Client #1's record was reviewed on 11/15/11 at 10:00 A.M. Client #1's record indicated he had an ISP dated 9/28/11. Client #1's ISP included a self administration of medication goal to "pour his own water while taking his medications."</p> <p>An interview was conducted with the facility RN (Registered Nurse) on 11/15/11 at 1:55 P.M. The RN stated medication administration goals should be implemented "at each medication pass."</p> <p>An interview was conducted with the Manager of Residential Services (MRS)</p>				

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W0288	<p>on 11/15/11 at 2:08 P.M. The MRS stated medication administration goals should be implemented "Whenever they are scheduled to be ran."</p> <p>9-3-4(a)</p> <p>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on record review and interview, the facility failed to develop a desensitization plan for 1 of 2 clients (client #1) who required pre-medication (pre-med) sedation prior to medical/dental appointments.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/15/11 at 10:00 A.M. Client #1's record indicated he had an Individual Support Plan (ISP) dated 9/28/11. Client #1's record included a Risk Plan dated 8/30/11 indicating the following: "[Client #1] gets Lorazepam (Ativan) (anti-anxiety) 2 mg/milligrams 1 hour prior to annual physical and all dental appointments. Client #1's record indicated he had received the Lorazepam on 5/13/11 for a yearly physical, 7/28/11 for a dental appointment, and on 9/7/11 for the restoration of three broken teeth. There was no documentation in client #1's</p>	W0288	<p>A program will be developed for client #1 to desensitize him to medical and dental procedures. Programs will be reviewed for all clients. Any who need medication to allow safe provision of medical procedures will have desensitization programs developed if they do not already exist.</p> <p>Any time a medication for safe provision of medical procedures is reviewed by the Human Rights Committee, a copy of the desensitization program will be required as part of the review.</p> <p>Person Responsible: QIDP, Director of Residential Services</p>	12/21/2011

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W9999	<p>record to indicate he had any training program or goal to assist him in becoming more independent and tolerant with his medical/dental appointments.</p> <p>The RN (Registered Nurse) was interviewed on 11/15/11 at 1:55 P.M. The RN stated "Yes he (client #1) gets it (Lorazepam) before his physical and dental appointments." The RN indicated client #1's Lorazepam medication was part of client #1's risk plan, but she "was unsure if" client #1 had a desensitization plan.</p> <p>The Manager of Residential Services (MRS) was interviewed on 11/15/11 at 2:10 P.M. The MRS indicated client #1 had no desensitization plan available for review.</p> <p>9-3-5(a)</p> <p>State Findings</p> <p>460 IAC 9-3-1 Governing body</p> <p>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p>	W9999	<p>Staff persons will be retrained on the requirement to report any medication errors that involve omitted medications immediately. A <i>Checklist for Reporting Unusual Events and Incidents</i> will be used to document the date and time that incidents are reported. This will be reviewed by the Director of Residential Services and action</p>	12/21/2011	

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, for 2 of 5 Bureau of Developmental Disabilities Services (BDDS) reports, the facility failed to immediately report incidents for client #4 and #5's medication administration errors in accordance with State Law.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/14/11 at 10:30 A.M. including the BDDS reports for the time period between 11/14/10 and 11/14/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 5/25/11 for an incident on 5/20/11 at 8pm, indicated a facility staff failed to administer client #5's 8pm medications on 5/20/11. There was no indication why the incident had not been reported immediately to BDDS.</p> <p>-a BDDS report dated 5/25/11 for an incident on 5/22/11 at 8pm, indicated a facility staff failed to administer client #4's 8pm medications on 5/22/11. There was no indication why the incident had not been reported immediately to BDDS.</p> <p>An interview was conducted with the Manager of Residential Services (MRS)</p>		<p>will be taken when incidents are not reported timely.</p> <p>Person Responsible: Director of Residential Services</p>		

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	on 11/15/11 at 2:10 P.M. The MRS indicated she was unaware the reports had been submitted late. 9-3-1(b)(5)				