

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 11/23/2011
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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, IN46825
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>This visit was in conjunction with a post certification revisit (PCR) to the investigation of complaint #IN00093199 completed on August 3, 2011.</p> <p>Dates of survey: November 22 and 23, 2011.</p> <p>Facility number: 000929 Provider number: 15G415 AIMS number: 100244520</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/5/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0149	<p>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 staff neglected to follow their Standard Operating Procedures/Abuse and Neglect Policy by neglecting to ensure 1 of 5 clients who lived in the home (client</p>	W0149	<p>The facility has policies and procedures that prohibit mistreatment, neglect or abuse of the client. Staff persons are trained on these policies and procedures prior to working with clients and at</p>	12/23/2011

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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	<p>#5) received medical treatment as prescribed by her physician.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/22/11 at 10:20 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 11/22/10 and 11/22/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 9/21/11 for an incident on 9/16/11 at 9:30 P.M. indicated "[Name of Residential Supervisor (RS)], RS, was given instructions by agency RN on 9/16/11 to write in the medication record (MAR) for [client #5] to have ear drops that were prescribed by her physician and being dropped off at the group home that evening by [Name of Pharmacy]. [Client #5] has infection in her ear. [Name of RS] did not write the instructions in the MAR." Plan to Resolve: "[Name of RS] was suspended today for alleged neglect. Agency investigator will complete investigation...."</p> <p>-a follow-up BDDS report dated 9/28/11 for the incident on 9/16/11 indicated "[Client #5's] physician ordered ear drops for her on 9/15/11. [The RS] received an</p>		<p>least annually thereafter.</p> <p>Staff persons will be retrained on the agency's policy prohibiting abuse and neglect.</p> <p>The agency's SOP on <i>Medication Administration</i> has been revised to include instructions to staff persons on prescriptions that are given at medical appointments to ensure that they are filled, documented and administered timely. Staff persons will be trained on the agency's revised <i>Medication Administration</i> SOP.</p> <p>Person Responsible: Residential Supervisor</p>	

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	<p>email from the RN on 9/15/11 instructing her to write the order for the ear drops on the MAR. [The RS] did not document the ear drops on the MAR. The ear drops were not administered until 9/18/11... [Client #5] had surgery on her ear 6/30/11...(client #5's) mother said [client #5] had complaints of ear pain and odor from her ear... [Name of RN] assessed [client #5's] ear on 9/14/11. She smelled a foul odor and saw white drainage. "the RN contacted client #5's ENT (ear, nose and throat doctor) and was given the order for ear drops to be given twice a day. Client #5 did not receive her ear drops until 9/18/11 at the P.M. dose.</p> <p>The original BDDS report indicated the order for ear drops was received from the doctor on 9/16/11. The follow-up BDDS report indicated the order was obtained on 9/15/11. Staff did not indicate which was the correct date.</p> <p>-a BDDS report dated 10/11/11 for an incident on 10/7/11 at 12:00 P.M. indicated the following: "A group home staff reported to the agency nursing staff that a record of medical appointment was found dated 10/6/11 which stated that [client #5] was to receive ear drops for a medical condition. It was found that these orders were not documented in the MAR per agency policy and that the ear drops</p>				

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	<p>were not given as a result until the day after the appointment. Thus, this situation has been deemed to be an allegation of medical neglect. The two staff involved have been suspended pending the outcome of the investigation...."</p> <p>-a follow-up BDDS report dated 10/18/11 for the incident on 10/7/11 indicated "The allegations of neglect were substantiated... The staff person [Name of Residential Supervisor] deemed to be the responsible party was subsequently terminated from her position with Easter Seals ARC of North East Indiana."</p> <p>The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 11/22/11 at 11:42 A.M.. The policy indicated "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</p>				

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	<p>exploitation...F.) Medications and treatments will be administered as specified by physician orders and as taught in the 'Living in the Community' Core A and Core B ... it will be a medication error if medications and/or treatments are not administered as specified by the physician's orders...termination will be the result for any of the following: 1. Intentionally concealing a medication error or failing to report a known medication error...The QMRP (Qualified Mental Retardation Professional) will submit a BDDS follow-up report 7 (seven) calendar days or 5 (five) business days (whichever is sooner) after the incident."</p> <p>The Manager of Residential Services (MRS) was interviewed on 11/23/11 at 10:40 A.M.. When asked about the medication errors which occurred for client #5, the MRS stated, "The agency did consider the second incident as neglect." The MRS indicated there had been a medication error made by the RM in September for not documenting client #5's ear drops on the MAR. The RM was put on probationary status at the time, and then in October the RM again neglected to write client #5's order for ear drops on the MAR. When asked about the agency's policy, the MRS stated, "She was not following policy, that is why she is no</p>			

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W0153	<p>longer working here."</p> <p>9-3-2(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> <p>Based on record review and interview, the facility failed to immediately report 2 of 2 incidents of medical neglect for 1 of 5 clients (client #5) as indicated in 2 of 51 BDDS reports reviewed, to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/22/11 at 10:20 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 11/22/10 and 11/22/11. The BDDS reports indicated the following:</p>	W0153	<p>Staff persons will be retrained on following procedures on immediate reporting of any allegations of neglect. Staff persons will continue to be trained prior to working with clients and annually thereafter.</p> <p><i>A Checklist for Reporting Unusual Events and Incidents</i> will be used to document the date and time that allegations of abuse, neglect or mistreatment of a client are reported to the administrator and the Bureau of Developmental Disabilities Services. This form will be reviewed by the Director of Residential Services who will take needed action regarding any untimely reports.</p> <p>Person Responsible: Director of Residential Services</p>	12/23/2011	

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	<p>medical condition. It was found that these orders were not documented in the MAR per agency policy and that the ear drops were not given as a result until the day after the appointment. Thus, this situation has been deemed to be an allegation of medical neglect. The two staff involved have been suspended pending the outcome of the investigation...." There was no documentation available for review to indicate why the incident was not reported to BDDS timely.</p> <p>The Manager of Residential Services (MRS) was interviewed on 11/23/11 at 10:40 A.M.. When asked about the reports being late, the MRS indicated she was aware the reports had been late.</p> <p>9-3-2(a)</p>				
W0368	<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 ensure 1 of 5 clients who lived in the home (client #5) was</p>	W0368	<p>The agency's SOP on <i>Medication Administration</i> has been revised to include instructions to staff persons</p>	12/23/2011	

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	<p>administered her medications as prescribed by her physician.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/22/11 at 10:20 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 11/22/10 and 11/22/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 9/21/11 for an incident on 9/16/11 at 9:30 P.M. indicated "[Name of Residential Supervisor (RS)], RS, was given instructions by agency RN on 9/16/11 to write in the medication record (MAR) for [client #5] to have ear drops that were prescribed by her physician and being dropped off at the group home that evening by [Name of Pharmacy]. [Client #5] has infection in her ear. [Name of RS] did not write the instructions in the MAR." Plan to Resolve: "[Name of RS] was suspended today for alleged neglect. Agency investigator will complete investigation...."</p> <p>-a follow-up BDDS report dated 9/28/11 for the incident on 9/16/11 indicated "[Client #5's] physician ordered ear drops for her on 9/15/11. [The RS] received an</p>		<p>on prescriptions that are given at medical appointments to ensure that they are filled, documented and administered timely. Staff persons will be trained on the agency's revised <i>Medication Administration SOP</i>.</p> <p>The correct date that the order for client #5's ear drops was given is September 15, 2011. The original BDDS report that stated September 16, 2011 was in error.</p> <p>Medication administration will be observed by the Supervisor once per staff person per quarter and by the Nurse at least once per staff person per year. These observations will be documented and any errors in administration of medication will be addressed per the agency's medication error SOP.</p> <p>Person Responsible: Director of Residential Services / Nursing Supervisor</p>	

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	<p>email from the RN on 9/15/11 instructing her to write the order for the ear drops on the MAR. [The RS] did not document the ear drops on the MAR. The ear drops were not administered until 9/18/11... [Client #5] had surgery on her ear 6/30/11...(client #5's) mother said [client #5] had complaints of ear pain and odor from her ear... [Name of RN] assessed [client #5's] ear on 9/14/11. She smelled a foul odor and saw white drainage. "the RN contacted client #5's ENT (ear, nose and throat doctor) and was given the order for ear drops to be given twice a day. Client #5 did not receive her ear drops until 9/18/11 at the P.M. dose.</p> <p>The original BDDS report indicated the order for ear drops was received from the doctor on 9/16/11. The follow-up BDDS report indicated the order was obtained on 9/15/11. Staff did not indicate which was the correct date.</p> <p>-a BDDS report dated 10/11/11 for an incident on 10/7/11 at 12:00 P.M. indicated the following: "A group home staff reported to the agency nursing staff that a record of medical appointment was found dated 10/6/11 which stated that [client #5] was to receive ear drops for a medical condition. It was found that these orders were not documented in the MAR per agency policy and that the ear drops</p>				

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	<p>were not given as a result until the day after the appointment.</p> <p>Client #5's record was reviewed on 11/22/11 at 4:02 P.M.. Client #5's record indicated she had surgery on her ear on 6/30/11 to insert an ear tube. Client #5 had been diagnosed with a cholesteatoma (ear infection around the ear tube) in her middle ear and her physician had ordered ear drops for her on 9/15/11. Client #5's record indicated she went for a follow-up appointment with her ENT on 10/6/11. The ENT ordered ear drops (four) in left ear twice daily for 14 (fourteen) days.</p> <p>The Manager of Residential Services (MRS) was interviewed on 11/23/11 at 10:40 A.M.. When asked if client #5 had received her medications as prescribed by her physician, the MRS stated, "Not immediately."</p> <p>9-3-6(a)</p>				