

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 4420 WOODSTOCK DR FORT WAYNE, IN 46815
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 4, 5 and 6, 2016.</p> <p>Facility number: 000713 Provider number: 15G180 AIM number: 100243170</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/11/16.</p>	W 0000		
W 0268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based upon observation and interview, the facility failed for 1 additional client (client #4) to promote dignity by failing to ensure she wore clean clothing.</p> <p>Findings include:</p> <p>Observations were completed at the</p>	W 0268	<p>The dayprogram staff will be retrained on ensuring that clients are wearing cleanclothing</p> <p>Person Responsible: Director of Adult Day Center CompletionDate: 2/5/16</p> <p>The QIDP will complete two observations of Adult Day Center per week for 4 weeks and then one observation per month for 3</p>	02/05/2016

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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W 0336 Bldg. 00	<p>facility owned day services on 1/5/16 from 12:15 PM until 12:40 PM. Client #4 watched TV wearing a shirt that had food spillage down the front of her shirt.</p> <p>Day services staff #1 was interviewed on 1/5/16 at 12:30 PM and indicated client #4 had a change of clothing to use when she was wet. She indicated client #4 used a clothing protector during meals, but sometimes food slipped underneath the protector onto her clothing. Day services staff then continued working on the computer at the back of the room and did not change client #4's shirt.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/5/16 at 3:17 PM and indicated staff should have changed client #4's shirt when soiled.</p> <p>9-3-5(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based upon record review and interview for 3 of 3 sampled clients (clients #1, #2</p>	W 0336	<p>months checking to ensure that clients are wearing clean clothing. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP Completion Date: 2/5/16</p> <p>The agency nurses will be retrained to conduct nursing assessments of each client at least quarterly</p>	02/05/2016			

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W 0484 Bldg. 00	<p>and #3), the facility's nursing services failed to complete a nursing assessment on a quarterly basis.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/5/16 at 2:39 PM. There was no evidence of nursing assessments from 11/4/14 until 4/24/15. There was no evidence in the record of a need for a medical care plan for client #1.</p> <p>2. Client #2's record was reviewed on 1/5/16 at 12:43 PM. There was no evidence of nursing assessments from 10/31/14 until 4/8/15. There was no evidence in the record of a need for a medical care plan for client #2.</p> <p>3. Client #3's record was reviewed on 1/5/16 at 1:47 PM. There was no evidence of nursing assessments from 11/4/14 until 4/7/15. There was no evidence in the record of a need for a medical care plan for client #3.</p> <p>The Residential Director was interviewed on 1/6/16 at 11:00 AM and indicated the previous nursing staff had not completed the nursing assessments in a timely fashion.</p> <p>9-3-6(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p>			W 0484	<p>PersonResponsible: Nurse Supervisor CompletionDate: 2/5/16</p> <p>The Director of Group Home Services will complete an audit of client records quarterly to ensure that quarterly nursing assessments are being completed</p> <p>PersonResponsible: Department Director CompletionDate: 2/5/16</p> <p>The group home staff will be</p>		02/05/2016

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	<p>Based upon observation, record review and interview, the facility failed for 1 of 3 sampled clients (client #3) to provide adaptive eating equipment per his dining plan.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 1/4/16 from 4:30 PM until 5:45 PM. Client #3 did not want the chicken and noodles on the menu and staff #4 prepared scrambled eggs at the request of client #3 and placed them on a regular dinner plate in front of client #3. Client #3 placed his mouth at the edge of the plate and spooned the eggs into his mouth causing spillage onto the table.</p> <p>Client #3's record was reviewed on 1/5/16 at 1:47 PM. A dining plan dated 1/6/15 indicated client #3 was to utilize a divided plate for meals.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/5/16 at 3:17 PM and indicated client #3 should have been provided a divided plate as indicated in his dining plan.</p> <p>9-3-8(a)</p>		<p>retrained on using the clients' adaptive equipment.</p> <p>PersonResponsible: Group Home Supervisor CompletionDate: 2/5/16</p> <p>The QIDP will complete an observation of the group home during meal times twice a week for 4 weeks and then once a month ongoing checking for use of adaptive equipment. The observations will be documented and any issues noted will be corrected.</p> <p>PersonResponsible: QIDP CompletionDate: 2/5/16</p>	