STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G180	A. BUILDING 00 B. WING	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTER SEALS ARC OF NORTHEAST	4420 WOODSTOCK DR FORT WAYNE, IN 46815

(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
W0000	This visit was for the fundamental recertification and state licensure survey. This visit included the investigation of complaint #IN00117768. Complaint #IN00117768: SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W104, W149, W153, W331 and W368. Dates of Survey: October 31, and November 1, 2, 7, 8 and 9, 2012. Facility number: 000713 Provider number: 15G180 AIM number: 100243170 Surveyor: Kathy J. Wanner, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/15/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed to exercise operating direction over the facility to establish an effective system for procuring medications ordered after hours and/or needing authorization for payment for the medications ordered after hours, resulting in 1 of 3 sampled clients (client C) failing to receive his medication as ordered by his physician. Findings include: The facility records were reviewed on 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/21/11 until 11/1/12. The BDDS reports indicated: A BDDS report dated 10/5/12 for 9/17/12 at 4:00 P.M. indicated "...Nursing staff reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (ear wax remover) after business hours. The on call nurse was notified and was asked permission if it was ok to get the ear drops ordered on Monday 9/17/12 from the nursing supervisor. Permission was given. On 9/17/12 the prescription was	W0104	W104 The nursing supervisor will develop a procedure to procure medications ordered after hours and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will train all nursing staff on this procedure. The nursing supervisor will monitor all medication orders to ensure timely delivery to clients per physician orders. The Director of Residential Services will ensure this policy becomes a part of the Residential Department SOP. Person Responsible: Nursing supervisor and Director of Residential Services Completion Date: December 9, 2012	12/09/2012

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	faxed to the pharmacy and needed approval from the nursing supervisor to send the ear drops. That same evening, [name of group home] staff notified the nursing supervisor that the ear drops were not in the home. On 9/19/12 nursing staff notified the nursing supervisor about [client C's] needing his ear drops as he had not yet received them. The nursing supervisor stated she had contacted the pharmacy and had faxed over the paper regarding the ear drops. On 9/24/12 nursing staff let the nursing supervisor know [client C] had never received his ear drops and the pharmacy reported that the nursing supervisor had never called or sent back the letter confirming payment for the delivery. This incident is considered to be an allegation of neglect. The nursing supervisor involved in this incident [Name of RNS] has been suspended pending the outcome of an investigation. Nursing staff report that [client C] does not appear to have suffered any negative outcomes as a result of his missed ear drops." A BDDS follow up report dated 10/10/12 indicated "An investigation into this matter was conducted and the results were presented to the Easter Seals ARC abuse and neglect committee. The abuse and neglect committee found that the allegation of neglect was not			

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	substantiated. On 9/17/12 the ear drops were ordered from the pharmacy. On 9/18/12 the pharmacy alerted the nursing supervisor that [client C's] insurance would not pay for the ear drops. The nursing supervisor completed the forms securing payment to the pharmacy from Easter Seals ARC and faxed them to the pharmacy on 9/19/12. The pharmacy did not receive the fax until 9/19/12. The ear drops were delivered on 9/19/12. [Client C] did receive his ear drops and did not experience any adverse affects from the delay due to payment issues. His doctor was notified and had no recommendations." Client C's record was reviewed on 11/7/12 at 2:12 P.M.. Client C's record included a Record of Medical Appointment dated 9/14/12 at 10:20 A.M.. The appointment form indicated "Debrox 4 (four) drops both ear canals for 4 days for ear wax ...no new changes other than Debrox." A review of the 9/2012 EMAR (electronic medication administration record) was completed on 11/1/12 at 2:48 P.M.. The EMAR indicated client C received his Debrox ear drops on 9/20/12, 9/21/12, 9/22/12, and 9/23/12. A review of the facility internal			

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	investigation documentation dated 10/9/12 was completed on 11/8/12 at 12:05 P.M.. The investigation summary indicated "...The committee recommends that [name of RN #1] receive a written warning for late reporting which is standard discipline for this offense." The written statements from those involved in the incident indicated: -The written statement dated 10/4/12 by RN #1 indicated "On 9/14/12 [client C] received a prescription for Debrox ear drops for wax removal for both of his ears. The script was received after the nursing office was closed and the on-call nurse was notified about the ear drops from staff at [name] group home. The on-call nurse told the [GH] staff that since it is only for ear drop removal, the drops can wait until Monday. On Monday 9/17/12, the prescription for the ear drops was re-faxed and a form for a non-covered medication came thru (sic) on the fax machine for the Debrox ear drops. The form was placed in [name of RNS's] mailbox on Monday 9/17/12 for her approval. That evening [GH] staff notified the nurse that [client C] did not have the ear drops (per EMAR). After checking the EMAR on Thursday (9/20/12) and seeing that every day for the past 4 (four) days, the medication had been held due to the medication being			

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	unavailable. I (RN #1) called [name] pharmacy and spoke with someone in customer service department. I asked her why hadn't the medication been sent and the technician responded that they never received a verbal ok to bill facility or the form stating okay to bill the facility by [name] RNS. I then emailed [name] RNS on Thursday 9/20/12 regarding that [client C] did not receive the ear drops and a med (medication) error form should be filled out due to the medication being started almost a week late. The response I received from [name] RNS was that she had faxed the form and spoke with the pharmacy and she will look into it. I never heard back from [name] RNS if the ear drops were received or not. I did check the EMAR and [client C] received the ear drops on 9/20/12-9/23/12, and no med error form was ever filled out." -The written statement dated 10/5/12 by RNS indicated "On September 14th [name] GH had a four day order for ear drops to remove wax. It was ordered after 4:00 P.M. Friday. The Residential Supervisor (RS) called on-call Friday and on-call said it was ok to wait until Monday. I (RNS) did not know anything about this order until 7:30 P.M. on Monday night. I received a text from [name] RS asking if they could start the drops Tuesday because they had not			

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	come. I said yes, assuming it was a new order from Monday, then she sent me a text saying there was an approval in my box for the drops. [Name] RN #1 never told me she had stuck an approval in my box. I went to work Tuesday signed the approval and called the pharmacy to make sure the drops would be sent to the house that night. I didn't hear anything Tuesday or Wednesday, so I assumed they were at the house. Wednesday night I received an email from [name] RS saying that she still had not received the drops. I called the pharmacy again on Thursday to have them send the drops out. I asked [name] Residential Director (RD) if we could talk about it, and did she feel like it was an error since it was four day wax removal treatment. She said she did not feel like it was an error...." An interview was conducted with the RS on 11/7/12 at 3:15 P.M.. The RS stated, "Absolutely I faxed it to nurse [Name of RN #4] and pharmacy. It was after 4:00 P.M.. The staff (direct care staff at GH) usually do fax it, but they didn't. I did it when I got to work that day. Yes, it was a morning appointment." An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/7/12 at 3:01 P.M.. The QDDP stated, "Normally we			

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	fax to pharmacy if no problem with payment they will deliver it at least by the next day to the house. Since it was a morning appointment it would have normally have been delivered that night. I think if they need approval for payment then [name] RD or [name] RNS must authorize it to be sent." An interview was conducted over the phone on 11/9/12 at 11:06 A.M. with the RD of the group homes. The RD stated, "We do have a system for medications ordered after hours. If it is something the nurse deems can wait until Monday, they wait until Monday. If it is something that can not wait the nurse gives authorization. Nursing judgement is practiced. If it is a long term problem they contact me. Normal practice is to fax the pharmacy, get any approvals needed and start within a day or two. Normally any appointment forms with or without medication changes are brought in on the next route. If it was a morning appointment it should have come in on the afternoon route that same day (2:00-3:00 P.M.)...." The Medication Procedures Policy dated 10/24/12 was reviewed on 11/8/12 at 1:15 P.M.. The procedure indicated "17. All paperwork from appointments shall be returned to the nursing department as soon as possible on the same day of the			

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	appointment...18. The nurse/supervisor then faxes the prescriptions to the pharmacy. 19. ALL MEDICATION CHANGES MUST BE INITIATED (faxed, called in, dropped off to pharmacy) WITHIN 24 (twenty-four) HOURS OF RECEIVING A SCRIPT. If the medication or treatment has not started within 24 hours appropriate documentation must be completed stating why." The procedure did not indicate how medications would be procured if the order was received after hours or needed authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 at 10:39 A.M.. When asked if the facility staff had followed the facility policies, the LIA stated, "They did not follow policy for reporting a medication error." The LIA indicated she was not sure what the system was for ordering medications after hours or authorizing payment for medications. The LIA stated, "I do not know the answer, I will need to look." This Federal tag relates to complaint #IN00117768. 9-3-1(a)			

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W0149	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 and medication procedures for 1 of 3 sampled clients (client C) by not ensuring he received his medication when ordered by his physician. Findings include: The facility records were reviewed on 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/21/11 until 11/1/12. The BDDS reports indicated: A BDDS report dated 10/5/12 for 9/17/12 at 4:00 P.M. indicated "...Nursing staff reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax softener) after business hours. The on call nurse was notified and was asked permission if it was ok to get the ear drops ordered on Monday 9/17/12 from the nursing supervisor. Permission was given. On 9/17/12 the prescription was faxed to the pharmacy and needed approval from the nursing supervisor to send the ear drops. That same evening,	W0149	W149 The facility has policies and procedures that prohibit mistreatment, neglect or abuse of the client. The nursing supervisor will develop a procedure to procure medications ordered after hours and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will train all nursing staff on this procedure. The nursing supervisor will monitor all medication orders to ensure timely delivery to clients per physician orders. The Director of Residential Services will ensure this policy becomes a part of the Residential Department SOP. Nursing supervisor will in-service nursing staff on the requirements to report medication errors. Nursing supervisor will train any new nursing staff and all nursing staff annually. Note, the person who reported the medication error late received disciplinary action and is no longer with the agency.	12/09/2012

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	[name of group home] staff notified the nursing supervisor that the ear drops were not in the home. On 9/19/12 nursing staff notified the nursing supervisor about [client C's] needing his ear drops as he had not yet received them. The nursing supervisor stated she had contacted the pharmacy and had faxed over the paper regarding the ear drops. On 9/24/12 nursing staff let the nursing supervisor know [client C] had never received his ear drops and the pharmacy reported that the nursing supervisor had never called or sent back the letter confirming payment for the delivery. This incident is considered to be an allegation of neglect. The nursing supervisor involved in this incident [Name of RNS] has been suspended pending the outcome of an investigation. Nursing staff report that [client C] does not appear to have suffered any negative outcomes as a result of his missed ear drops." A BDDS follow up report dated 10/10/12 indicated "An investigation into this matter was conducted and the results were presented to the Easter Seals ARC abuse and neglect committee. The abuse and neglect committee found that the allegation of neglect was not substantiated. On 9/17/12 the ear drops were ordered from the pharmacy. On 9/18/12 the pharmacy alerted the nursing		Group home supervisor will in-service group home staff on medication procedure #17, regarding getting paperwork from client appointments to the nurses as soon as possible or making contact with the nurse as soon as possible. Person Responsible: Nursing supervisor, Group home supervisor and Director of Residential Services Completion Date: December 9, 2012	

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	supervisor that [client C's] insurance would not pay for the ear drops. The nursing supervisor completed the forms securing payment to the pharmacy from Easter Seals ARC and faxed them to the pharmacy on 9/19/12. The pharmacy did not receive the fax until 9/19/12. The ear drops were delivered on 9/19/12. [Client C] did receive his ear drops and did not experience any adverse affects from the delay due to payment issues. His doctor was notified and had no recommendations." Client C's record was reviewed on 11/7/12 at 2:12 P.M.. Client C's record included a Record of Medical Appointment dated 9/14/12 at 10:20 A.M.. The appointment form indicated "Debrox 4 (four) drops both ear canals for 4 days for ear wax ...no new changes other than Debrox." A review of the 9/2012 EMAR (electronic medication administration record) was completed on 11/1/12 at 2:48 P.M.. The EMAR indicated client C received his Debrox ear drops on 9/20/12, 9/21/12, 9/22/12, and 9/23/12. A review of the facility internal investigation documentation dated 10/9/12 was completed on 11/8/12 at 12:05 P.M.. The investigation summary			

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	indicated "...The committee recommends that [name of RN #1] receive a written warning for late reporting which is standard discipline for this offense." The written statements from those involved in the incident indicated: -The written statement dated 10/4/12 by RN #1 indicated "On 9/14/12 [client C] received a prescription for Debrox ear drops for wax removal for both of his ears. The script was received after the nursing office was closed and the on-call nurse was notified about the ear drops from staff at [name] group home. The on-call nurse told the [GH] staff that since it is only for ear drop removal, the drops can wait until Monday. On Monday 9/17/12, the prescription for the ear drops was re-faxed and a form for a non-covered medication came thru (sic) on the fax machine for the Debrox ear drops. The form was placed in [name of RNS's] mailbox on Monday 9/17/12 for her approval. That evening [GH] staff notified the nurse that [client C] did not have the ear drops (per EMAR). After checking the EMAR on Thursday (9/20/12) and seeing that every day for the past 4 (four) days, the medication had been held due to the medication being unavailable. I (RN #1) called [name] pharmacy and spoke with someone in customer service department. I asked her			

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	why hadn't the medication been sent and the technician responded that they never received a verbal ok to bill facility or the form stating okay to bill the facility by [name] RNS. I then emailed [name] RNS on Thursday 9/20/12 regarding that [client C] did not receive the ear drops and a med (medication) error form should be filled out due to the medication being started almost a week late. The response I received from [name] RNS was that she had faxed the form and spoke with the pharmacy and she will look into it. I never heard back from [name] RNS if the ear drops were received or not. I did check the EMAR and [client C] received the ear drops on 9/20/12-9/23/12, and no med error form was ever filled out." -The written statement dated 10/5/12 by RNS indicated "On September 14th [name] GH had a four day order for ear drops to remove wax. It was ordered after 4:00 P.M. Friday. The Residential Supervisor (RS) called on-call Friday and on-call said it was ok to wait until Monday. I (RNS) did not know anything about this order until 7:30 P.M. on Monday night. I received a text from [name] RS asking if they could start the drops Tuesday because they had not come. I said yes, assuming it was a new order from Monday, then she sent me a text saying there was an approval in my			

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	box for the drops. [Name] RN #1 never told me she had stuck an approval in my box. I went to work Tuesday signed the approval and called the pharmacy to make sure the drops would be sent to the house that night. I didn't hear anything Tuesday or Wednesday, so I assumed they were at the house. Wednesday night I received an email from [name] RS saying that she still had not received the drops. I called the pharmacy again on Thursday to have them send the drops out. I asked [name] Residential Director (RD) if we could talk about it, and did she feel like it was an error since it was four day wax removal treatment. She said she did not feel like it was an error...." An interview was conducted with the RNS on 11/1/12 at 3:02 P.M.. The RNS stated, "The drops did not arrive in the home until the 20th. He missed the drops on 9/17, 9/18, and 9/19. The doctor did not have any problems and the pharmacy did not give any explanation why it was not sent on 9/17. The order was for only four days. In the BDDS report it was not in the house on 9/24 because the order was already given and discontinued by that date. He did get it for four days 9/20, 9/21, 9/22 and 9/23." An interview was conducted with the RS on 11/7/12 at 3:15 P.M.. The RS stated,			

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	"Absolutely I faxed it to nurse [Name of RN #4] and pharmacy. It was after 4:00 P.M.. The staff (direct care staff at GH) usually do fax it, but they didn't. I did it when I got to work that day. Yes, it was a morning appointment." An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/7/12 at 3:01 P.M.. The QDDP stated, "Normally we fax to pharmacy if no problem with payment they will deliver it at least by the next day to the house. Since it was a morning appointment it would have normally have been delivered that night. I think if they need approval for payment then the [name] RD or [name] RNS must authorize it to be sent." An interview was conducted over the phone on 11/9/12 at 11:06 A.M. with the RD of the group homes. The RD stated, "We do have a system for medications ordered after hours. If it is something the nurse deems can wait until Monday, they wait until Monday. If it is something that can not wait the nurse gives authorization. Nursing judgement is practiced. If it is a long term problem they contact me. Normal practice is to fax the pharmacy, get any approvals needed and start within a day or two. Normally any appointment forms with or without medication changes			

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	are brought in on the next route. If it was a morning appointment it should have come in on the afternoon route that same day (2:00-3:00 P.M.). We were not going to report it to BDDS because the medication was not in the house, it was not an omission because it was not put in the EMAR. We did not deem it an omission because it was a nursing decision to wait until Monday." The Medication Procedures Policy dated 10/24/12 was reviewed on 11/8/12 at 1:15 P.M.. The procedure indicated "17. All paperwork from appointments shall be returned to the nursing department as soon as possible on the same day of the appointment...18. The nurse/supervisor then faxes the prescriptions to the pharmacy. 19. ALL MEDICATION CHANGES MUST BE INITIATED (faxed, called in, dropped off to pharmacy) WITHIN 24 (twenty-four) HOURS OF RECEIVING A SCRIPT. If the medication or treatment has not started within 24 hours appropriate documentation must be completed stating why." The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 11/8/12 at 11:42 A.M.. The policy indicated "A.)...Abuse, neglect,			

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	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...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." An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 at 10:39 A.M.. When asked if the facility			

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	staff had followed the facility policies, the LIA stated, "They did not follow policy for reporting a medication error." The LIA indicated she was not sure what the system was for ordering medications after hours or authorizing payment for medications. The LIA stated, "I do not know the answer, I will need to look." This Federal tag relates to complaint #IN00117768. 9-3-2(a)			

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W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, the facility staff failed to immediately report a medication error (allegation of neglect) for 1 of 3 sampled clients (client C) by neglecting to ensure he received his medication as ordered by physician for six days, as indicated in 1 of 16 Bureau of Developmental Disabilities Services (BDDS) reports reviewed, to the administrator and to other officials in accordance with state law. Findings include: The facility records were reviewed on 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/21/11 until 11/1/12. The BDDS reports indicated: A BDDS report dated 10/5/12 for 9/17/12 at 4:00 P.M. indicated "...Nursing staff reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax softener) after business hours. The on call nurse was notified and was asked	W0153	W153 The facility has policies and procedures that prohibit mistreatment, neglect or abuse of the client. The nursing supervisor will develop a procedure to procure medications ordered after hours and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will train all nursing staff on this procedure. The nursing supervisor will monitor all medication orders to ensure timely delivery to clients per physician orders. Nursing supervisor will in-service nursing staff on the requirements to report medication errors. Nursing supervisor will train any new nursing staff and all nursing staff annually. Note, the person who reported the medication error late received disciplinary action and is no longer with the agency. The Director of Residential	12/09/2012

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	permission if it was ok to get the ear drops ordered on Monday 9/17/12 from the nursing supervisor. Permission was given. On 9/17/12 the prescription was faxed to the pharmacy and needed approval from the nursing supervisor to send the ear drops. That same evening, [name of group home] staff notified the nursing supervisor that the ear drops were not in the home. On 9/19/12 nursing staff notified the nursing supervisor about [client C's] needing his ear drops as he had not yet received them. The nursing supervisor stated she had contacted the pharmacy and had faxed over the paper regarding the ear drops. On 9/24/12 nursing staff let the nursing supervisor know [client C] had never received his ear drops and the pharmacy reported that the nursing supervisor had never called or sent back the letter confirming payment for the delivery. This incident is considered to be an allegation of neglect. The nursing supervisor involved in this incident [Name of RNS] has been suspended pending the outcome of an investigation. Nursing staff report that [client C] does not appear to have suffered any negative outcomes as a result of his missed ear drops." The BDDS report was not submitted until 10/5/12 for the 9/17/12 medication error. An interview was conducted over the		Services will ensure this policy becomes a part of the Residential Department SOP. Person Responsible: Nursing supervisor and Director of Residential Services Completion Date: December 9, 2012	

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	phone on 11/9/12 at 11:06 A.M. with the RD of the group homes. The RD stated, "...We were not going to report it to BDDS because the medication was not in the house, it was not an omission because it was not put in the EMAR. We did not deem it an omission because it was a nursing decision to wait until Monday." An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 at 10:39 A.M.. When asked if the facility staff had followed the facility policies, the LIA stated, "They did not follow policy for reporting a medication error." The LIA indicated the medication error had been reported late. This Federal tag relates to complaint #IN00117768. 9-3-2(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility nursing staff failed to ensure 1 of 3 sampled clients (client C) received his medication when ordered by his physician. Findings include: The facility records were reviewed on 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/21/11 until 11/1/12. The BDDS reports indicated: A BDDS report dated 10/5/12 for 9/17/12 at 4:00 P.M. indicated "...Nursing staff reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax softener) after business hours. The on call nurse was notified and was asked permission if it was ok to get the ear drops ordered on Monday 9/17/12 from the nursing supervisor. Permission was given. On 9/17/12 the prescription was faxed to the pharmacy and needed approval from the nursing supervisor to send the ear drops. That same evening, [name of group home] staff notified the nursing supervisor that the ear drops were not in the home. On 9/19/12 nursing staff	W0331	W331 The nursing supervisor will develop a procedure to procure medications ordered after hours and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will train all nursing staff on this procedure. The nursing supervisor will monitor all medication orders to ensure timely delivery to clients per physician orders. The Director of Residential Services will ensure this policy becomes a part of the Residential Department SOP. Person Responsible: Nursing supervisor and Director of Residential Services Completion Date: December 9, 2012	12/09/2012

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	notified the nursing supervisor about [client C's] needing his ear drops as he had not yet received them. The nursing supervisor stated she had contacted the pharmacy and had faxed over the paper regarding the ear drops. On 9/24/12 nursing staff let the nursing supervisor know [client C] had never received his ear drops and the pharmacy reported that the nursing supervisor had never called or sent back the letter confirming payment for the delivery. This incident is considered to be an allegation of neglect. The nursing supervisor involved in this incident [Name of RNS] has been suspended pending the outcome of an investigation. Nursing staff report that [client C] does not appear to have suffered any negative outcomes as a result of his missed ear drops." A BDDS follow up report dated 10/10/12 indicated "An investigation into this matter was conducted and the results were presented to the Easter Seals ARC abuse and neglect committee. The abuse and neglect committee found that the allegation of neglect was not substantiated. On 9/17/12 the ear drops were ordered from the pharmacy. On 9/18/12 the pharmacy alerted the nursing supervisor that [client C's] insurance would not pay for the ear drops. The nursing supervisor completed the forms			

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	securing payment to the pharmacy from Easter Seals ARC and faxed them to the pharmacy on 9/19/12. The pharmacy did not receive the fax until 9/19/12. The ear drops were delivered on 9/19/12. [Client C] did receive his ear drops and did not experience any adverse affects from the delay due to payment issues. His doctor was notified and had no recommendations." Client C's record was reviewed on 11/7/12 at 2:12 P.M.. Client C's record included a Record of Medical Appointment dated 9/14/12 at 10:20 A.M.. The appointment form indicated "Debrox 4 (four) drops both ear canals for 4 days for ear wax ...no new changes other than Debrox." A review of the 9/2012 EMAR (electronic medication administration record) was completed on 11/1/12 at 2:48 P.M.. The EMAR indicated client C received his Debrox ear drops on 9/20/12, 9/21/12, 9/22/12, and 9/23/12. An interview was conducted with the RS on 11/7/12 at 3:15 P.M.. The RS stated, "Absolutely I faxed it to nurse [Name of RN #4] and pharmacy. It was after 4:00 P.M.. The staff (direct care staff at GH) usually do fax it, but they didn't. I did it when I got to work that day. Yes, it was a			

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	morning appointment." An interview was conducted with the RNS on 11/1/12 at 3:02 P.M.. The RNS stated, "The drops did not arrive in the home until the 20th. He missed the drops on 9/17, 9/18, and 9/19. The doctor did not have any problems and the pharmacy did not give any explanation why it was not sent on 9/17. The order was for only four days. In the BDDS report it was not in the house on 9/24 because the order was already given and discontinued by that date. He did get it for four days 9/20, 9/21, 9/22 and 9/23." An interview was conducted with the Qualified Developmental Disabilities Professional (QDDP) on 11/7/12 at 3:01 P.M.. The QDDP stated, "Normally we fax to pharmacy if no problem with payment they will deliver it at least by the next day to the house. Since it was a morning appointment it would have normally have been delivered that night. I think if they need approval for payment then the [name] RD or [name] RNS must authorize it to be sent." An interview was conducted over the phone on 11/9/12 at 11:06 A.M. with the RD of the group homes. The RD stated, "We do have a system for medications ordered after hours. If it is something the			

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	nurse deems can wait until Monday, they wait until Monday. If it is something that can not wait the nurse gives authorization. Nursing judgement is practiced. If it is a long term problem they contact me. Normal practice is to fax the pharmacy, get any approvals needed and start within a day or two. Normally any appointment forms with or without medication changes are brought in on the next route. If it was a morning appointment it should have come in on the afternoon route that same day (2:00-3:00 P.M.). We were not going to report it to BDDS because the medication was not in the house, it was not an omission because it was not put in the EMAR. We did not deem it an omission because it was a nursing decision to wait until Monday." This Federal tag relates to complaint #IN00117768. 9-3-6(a)			

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W0368	483.460(k)(1) DRUG ADMINISTRATION 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 the physician's order for 1 of 3 sampled clients (client C). Findings include: The facility records were reviewed on 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/21/11 until 11/1/12. The BDDS reports indicated: A BDDS report dated 10/5/12 for 9/17/12 at 4:00 P.M. indicated "...Nursing staff reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax softener) after business hours. The on call nurse was notified and was asked permission if it was ok to get the ear drops ordered on Monday 9/17/12 from the nursing supervisor. Permission was given. On 9/17/12 the prescription was faxed to the pharmacy and needed approval from the nursing supervisor to send the ear drops. That same evening, [name of group home] staff notified the nursing supervisor that the ear drops were	W0368	W368 The nursing supervisor will develop a procedure to procure medications ordered after hours and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will train all nursing staff on this procedure. The nursing supervisor will monitor all medication orders to ensure timely delivery to clients per physician orders. The Director of Residential Services will ensure this policy becomes a part of the Residential Department SOP. Person Responsible: Nursing supervisor and Director of Residential Services Completion Date: December 9, 2012	12/09/2012

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTER SEALS ARC OF NORTHEAST	4420 WOODSTOCK DR FORT WAYNE, IN 46815

(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
	not in the home. On 9/19/12 nursing staff notified the nursing supervisor about [client C's] needing his ear drops as he had not yet received them. The nursing supervisor stated she had contacted the pharmacy and had faxed over the paper regarding the ear drops. On 9/24/12 nursing staff let the nursing supervisor know [client C] had never received his ear drops and the pharmacy reported that the nursing supervisor had never called or sent back the letter confirming payment for the delivery. This incident is considered to be an allegation of neglect. The nursing supervisor involved in this incident [Name of RNS] has been suspended pending the outcome of an investigation. Nursing staff report that [client C] does not appear to have suffered any negative outcomes as a result of his missed ear drops." A BDDS follow up report dated 10/10/12 indicated "An investigation into this matter was conducted and the results were presented to the Easter Seals ARC abuse and neglect committee. The abuse and neglect committee found that the allegation of neglect was not substantiated. On 9/17/12 the ear drops were ordered from the pharmacy. On 9/18/12 the pharmacy alerted the nursing supervisor that [client C's] insurance would not pay for the ear drops. The			

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	15G180	A. BUILDING 00 B. WING	11/09/2012

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	nursing supervisor completed the forms securing payment to the pharmacy from Easter Seals ARC and faxed them to the pharmacy on 9/19/12. The pharmacy did not receive the fax until 9/19/12. The ear drops were delivered on 9/19/12. [Client C] did receive his ear drops and did not experience any adverse affects from the delay due to payment issues. His doctor was notified and had no recommendations." Client C's record was reviewed on 11/7/12 at 2:12 P.M.. Client C's record included a Record of Medical Appointment dated 9/14/12 at 10:20 A.M.. The appointment form indicated "Debrox 4 (four) drops both ear canals for 4 days for ear wax ...no new changes other than Debrox." A review of the 9/2012 EMAR (electronic medication administration record) was completed on 11/1/12 at 2:48 P.M.. The EMAR indicated client C received his Debrox ear drops on 9/20/12, 9/21/12, 9/22/12, and 9/23/12. An interview was conducted with the RNS on 11/1/12 at 3:02 P.M.. The RNS stated, "The drops did not arrive in the home until the 20th. He missed the drops on 9/17, 9/18, and 9/19. The doctor did not have any problems and the pharmacy			

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	did not give any explanation why it was not sent on 9/17. The order was for only four days. In the BDDS report it was not in the house on 9/24 because the order was already given and discontinued by that date. He did get it for four days 9/20, 9/21, 9/22 and 9/23." An interview was conducted over the phone on 11/9/12 at 11:06 A.M. with the RD of the group homes. The RD stated, "We do have a system for medications ordered after hours. If it is something the nurse deems can wait until Monday, they wait until Monday. If it is something that can not wait the nurse gives authorization. Nursing judgement is practiced. If it is a long term problem they contact me. Normal practice is to fax the pharmacy, get any approvals needed and start within a day or two. Normally any appointment forms with or without medication changes are brought in on the next route. If it was a morning appointment it should have come in on the afternoon route that same day (2:00-3:00 P.M.). We were not going to report it to BDDS because the medication was not in the house, it was not an omission because it was not put in the EMAR. We did not deem it an omission because it was a nursing decision to wait until Monday." This Federal tag relates to complaint			

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