	T OF HEALTH AND HU R MEDICARE & MEDIO						1 APPROVED NO. 0938-0391
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	A. BUI	LDING	ONSTRUCTION 00	(X3) DATE SU COMPLE 11/09/2	URVEY FED
		100100	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	11/03/2	012
NAME OF	PROVIDER OR SUPPLIE	R			OODSTOCK DR		
EASTER	R SEALS ARC OF N	NORTHEAST		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG W0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	recertification a This visit include complaint #INO Complaint #INO SUBSTANTIA deficiencies rela- cited at W104, V W368. Dates of Survey November 1, 2, Facility number Provider number AIM number: Surveyor: Kat Surveyor III The following f	20117768: TED, Federal and State ated to the allegations are W149, W153, W331 and 7: October 31, and 7, 8 and 9, 2012. 2: 000713 2: 15G180 100243170 2: thy J. Wanner, Medical 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2	wo	000			
	460 IAC 9.	dings in accordance with mpleted 11/15/12 by Ruth cal Surveyor III.					
		NUDED (SUDDI JED DEDDESENTATRUES) S					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 11/30/2012

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	(X3) DATE SURVEY COMPLETED 11/09/2012		
NAME OF PI	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C	CODE			
			4420 WOODSTOCK DR FORT WAYNE, IN 46815					
EASTER	SEALS ARC OF I	NORTHEAST	FORT					
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC		
TAG	REGULATORY U	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)		DATE		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G180 11/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4420 WOODSTOCK DR EASTER SEALS ARC OF NORTHEAST FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG W0104 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. W0104 Based on record review and interview, the 12/09/2012 W104 The nursing supervisor will develop a procedure to procure governing body failed to exercise medications ordered after hours operating direction over the facility to and/or needing authorization for establish an effective system for payment to ensure timely procuring medications ordered after hours medication administration as and/or needing authorization for payment directed by client's physician. The nursing supervisor will train all for the medications ordered after hours, nursing staff on this procedure. resulting in 1 of 3 sampled clients (client The nursing supervisor will C) failing to receive his medication as monitor all medication orders to ensure timely delivery to clients ordered by his physician. per physician orders. The Director of Residential Services will Findings include: ensure this policy becomes a part of the Residential Department SOP. Person Responsible: The facility records were reviewed on Nursing supervisor and Director 11/1/12 at 8:00 A.M. including the of Residential Services Bureau of Developmental Disabilities Completion Date: December 9, Services (BDDS) reports from 11/21/11 2012 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVCP11

Facility ID: 000713

If continuation sheet

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PRINTED:

11/30/2012

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)]	MULTIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BI	JILDING	00		APLETED
		15G180	B. WI			11/09/201	
		D		STREET A	ADDRESS, CITY, STATE, ZIP	P CODE	
NAME OF 1	PROVIDER OR SUPPLIE	ĸ		4420 W	OODSTOCK DR		
EASTER	SEALS ARC OF N	NORTHEAST		FORT V	VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	I SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	faxed to the pha	armacy and needed					
	approval from t	he nursing supervisor to					
	send the ear dro	pps. That same evening,					
	[name of group	home] staff notified the					
		sor that the ear drops were					
		. On 9/19/12 nursing staff					
		sing supervisor about					
		ding his ear drops as he					
		eived them. The nursing					
	-	d she had contacted the					
	-	ad faxed over the paper					
		ar drops. On 9/24/12					
		the nursing supervisor					
	-	had never received his ear					
		harmacy reported that the					
		sor had never called or					
		tter confirming payment					
		. This incident is					
		e an allegation of neglect.					
		pervisor involved in this					
		of RNS] has been					
		ling the outcome of an					
	-	lursing staff report that					
		not appear to have					
	suffered any ne	gative outcomes as a result					
	of his missed ea	ar drops."					
	A BDDS follow	v up report dated 10/10/12					
		nvestigation into this					
		ducted and the results were					
		Easter Seals ARC abuse					
	-						
	-	nmittee. The abuse and					
	-	tee found that the					
	allegation of ne	giect was not					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CO UILDING	NSTRUCTION 00	COI	ATE SURVEY MPLETED
		15G180	B. WING			11/	/09/2012
	PROVIDER OR SUPPLIE	D	STREET ADDRESS, CITY, STATE, ZIP			IP CODE	
NAME OF	I KOVIDEK OK SOTTEIE				OODSTOCK DR		
EASTER	SEALS ARC OF N	NORTHEAST		FORT V	VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO T	ON SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY	r)	DATE
		On 9/17/12 the ear drops					
	were ordered fr	om the pharmacy. On					
	9/18/12 the pha	rmacy alerted the nursing					
	supervisor that	[client C's] insurance					
	would not pay f	for the ear drops. The					
	nursing supervi	sor completed the forms					
	securing payme	ent to the pharmacy from					
	Easter Seals AF	RC and faxed them to the					
	pharmacy on 9/	19/12. The pharmacy did					
	· ·	fax until 9/19/12. The ear					
	drops were deli	vered on 9/19/12. [Client					
	-	his ear drops and did not					
	-	adverse affects from the					
		yment issues. His doctor					
	was notified an	-					
	recommendatio						
	Client C's recor	d was reviewed on					
		P.M. Client C's record					
	included a Reco						
		ated 9/14/12 at 10:20					
	**	bintment form indicated					
		r) drops both ear canals for					
		/axno new changes					
	other than Debr						
		0.					
	A review of the	0/2012 EMAR (alastropia					
		9/2012 EMAR (electronic ninistration record) was					
		1/1/12 at 2:48 P.M The					
	<u>^</u>	ed client C received his					
		ps on 9/20/12, 9/21/12,					
	9/22/12, and 9/2	23/12.					
		Co. 114 June 1					
	A review of the	facility internal					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G180	A. BUILDING B. WING	00		COMPLETED 11/09/2012	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZI	P CODE		
EASTEF	R SEALS ARC OF I	NORTHEAST		WOODSTOCK DR ⁻ WAYNE, IN 46815			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		CONDECTION	(X5)	
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	COMPLETION DATE	
	investigation de	ocumentation dated					
	10/9/12 was co	mpleted on 11/8/12 at					
	12:05 P.M Th	e investigation summary					
	indicated "Th	e committee recommends					
	that [name of R	RN #1] receive a written					
	warning for late	e reporting which is					
	standard discip	line for this offense." The					
	written stateme	ents from those involved in					
	the incident ind	licated:					
	-The written sta	atement dated 10/4/12 by					
	RN #1 indicate	d "On 9/14/12 [client C]					
	received a pres	cription for Debrox ear					
	drops for wax r	emoval for both of his					
	ears. The script	t was received after the					
	nursing office v	was closed and the on-call					
	nurse was notif	ied about the ear drops					
	-	ame] group home. The					
		old the [GH] staff that since					
	-	r drop removal, the drops					
		Monday. On Monday					
	-	escription for the ear drops					
	was re-faxed an						
		edication came thru (sic)					
		hine for the Debrox ear					
	-	n was placed in [name of					
	-	x on Monday 9/17/12 for					
	~ ~	hat evening [GH] staff					
		rse that [client C] did not					
		ops (per EMAR). After					
	-	MAR on Thursday					
		eeing that every day for the					
	• • •	ys, the medication had					
	been held due t	to the medication being				1	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	î î	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLETED	
		15G180	B. WING	11/0	09/2012		
NAMEOE	PROVIDER OR SUPPLIE	D	STRE	ET ADDRESS, CITY, STATE, ZII	P CODE		
NAME OF	FRO VIDER OR SUFFLIE		4420	WOODSTOCK DR			
EASTER	R SEALS ARC OF I	NORTHEAST	FOR	RT WAYNE, IN 46815			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX		N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	unavailable. I (RN #1) called [name]					
	pharmacy and s	poke with someone in					
	customer servic	e department. I asked her					
	why hadn't the	medication been sent and					
	the technician r	esponded that they never					
	received a verb	al ok to bill facility or the					
	form stating ok	ay to bill the facility by					
		then emailed [name] RNS					
	on Thursday 9/2	20/12 regarding that [client					
	C] did not recei	ve the ear drops and a med					
	(medication) er	ror form should be filled					
	out due to the n	nedication being started					
	almost a week l	ate. The response I					
		[name] RNS was that she					
		orm and spoke with the					
		he will look into it. I never					
		n [name] RNS if the ear					
		eived or not. I did check					
	-	[client C] received the ear					
		2-9/23/12, and no med					
	-	ever filled out."					
	-The written sta	tement dated 10/5/12 by					
		"On September 14th					
		a four day order for ear					
		e wax. It was ordered after					
	-	y. The Residential					
) called on-call Friday and					
	· ·	vas ok to wait until					
		S) did not know anything					
		until 7:30 P.M. on					
		I received a text from					
		ng if they could start the					
		because they had not					
	I utops ruesuay	because they had not		1		1	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		struction 00	· · ·	TE SURVEY MPLETED
		15G180	B. WING			11/09/2012	
NAME OF	PROVIDER OR SUPPLIE		STR	REET AD	DRESS, CITY, STATE, ZIP (CODE	
NAME OF	PROVIDER OR SUPPLIE	IK	442	20 WO	ODSTOCK DR		
EASTEF	R SEALS ARC OF N	NORTHEAST	FO	RTW	AYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF COF	RRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		DATE
	come. I said yes	s, assuming it was a new					
	order from Mor	nday, then she sent me a					
	text saying ther	e was an approval in my					
	box for the drop	os. [Name] RN #1 never					
	told me she had	l stuck an approval in my					
	box. I went to v	vork Tuesday signed the					
	approval and ca	illed the pharmacy to make					
	sure the drops v	vould be sent to the house					
	that night. I did	n't hear anything Tuesday					
	or Wednesday,	so I assumed they were at					
		nesday night I received an					
		me] RS saying that she still					
	-	d the drops. I called the					
		n on Thursday to have					
		lrops out. I asked [name]					
		ector (RD) if we could talk					
		d she feel like it was an					
		as four day wax removal					
		said she did not feel like it					
	was an error'						
	An interview w	as conducted with the RS					
		15 P.M The RS stated,					
		axed it to nurse [Name of					
	-	armacy. It was after 4:00					
		(direct care staff at GH)					
		t, but they didn't. I did it					
		•					
	-	ork that day. Yes, it was a					
	morning appoir	itment.					
		an and that a 41 - 41 -					
		as conducted with the					
		lopmental Disabilities					
		DDP) on 11/7/12 at 3:01					
	P.M., The QDD	P stated, "Normally we					

TERS FO	R MEDICARE & MEDI	CAID SERVICES				OMB NO. 0938-0391		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED		
		15G180	B. WIN	G		11/09/2012		
IAME OF I	PROVIDER OR SUPPLIE	B	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					OODSTOCK DR			
ASTER	R SEALS ARC OF I	NORTHEAST		FORT V	VAYNE, IN 46815			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
REFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP			
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	-	y if no problem with						
		vill deliver it at least by the						
	next day to the	house. Since it was a						
	morning appoir	ntment it would have						
	normally have	been delivered that night. I						
	think if they ne	ed approval for payment						
	then [name] RI	O or [name] RNS must						
	authorize it to b	be sent."						
	An interview w	as conducted over the						
	phone on 11/9/	12 at 11:06 A.M. with the						
	-	p homes. The RD stated,						
	-	system for medications						
		ours. If it is something the						
		n wait until Monday, they						
		day. If it is something that						
		e nurse gives authorization.						
		nent is practiced. If it is a						
		lem they contact me.						
	e 1	e is to fax the pharmacy,						
	-	als needed and start within						
		formally any appointment						
	-							
		vithout medication changes						
	-	on the next route. If it was						
		bintment it should have						
		afternoon route that same						
	day (2:00-3:00	P.M.)"						
		n Procedures Policy dated						
		eviewed on 11/8/12 at 1:15						
	-	edure indicated "17. All						
		n appointments shall be						
		nursing department as						
	soon as possible	e on the same day of the						

TATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLI ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G180 IDENTIFICATION NUMBER: TAG SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATI appointment18. 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. I the medication or treatment has not started within 24 hours appropriate documentation must be completed statin why." The procedure did not indicate ho medications would be procured if the order was received after hours or neede authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 10.20 A M	A. BUILDINC B. WING	PLE CONSTRUC	TION	(X3) DATE S	UDVEV	
ASTER SEALS ARC OF NORTHEAST (4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT appointment18. 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. I the medication or treatment has not started within 24 hours appropriate documentation must be completed statin why." The procedure did not indicate he 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		J	00 сом 11/0		ate survey DMPLeted 1/09/2012	
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 HOURS OF RECEIVING A SCRIPT. I the medication or treatment has not started within 24 hours appropriate documentation must be completed statin why." The procedure did not indicate he medications would be procured if the order was received after hours or needer authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 						
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 started within 24 hours appropriate documentation must be completed stating why." The procedure did not indicate here 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 	.1					
documentation must be completed stating why." The procedure did not indicate he medications would be procured if the order was received after hours or needer authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12						
 why." The procedure did not indicate he medications would be procured if the order was received after hours or neede authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12 						
medications would be procured if the order was received after hours or needer authorization for payment.An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12	0					
order was received after hours or needer authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12	DW .					
authorization for payment. An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12	1					
An Interview was conducted with the Lead Internal Auditor (LIA) on 11/9/12	a					
Lead Internal Auditor (LIA) on 11/9/12						
10.20 A M W/L	at					
10:39 A.M When asked if the facility						
staff had followed the facility policies,	he					
LIA stated, "They did not follow policy						
for reporting a medication error." The L						
indicated she was not sure what the						
system was for ordering medications af	ter					
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)						

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO	NSTRUCTION		E SURVEY LETED
AND FLAN C	F CORRECTION	15G180	A. BU B. WI		00	11/09)/2012
NAME OF PH	ROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP COI OODSTOCK DR	DE	
EASTER	SEALS ARC OF	NORTHEAST			VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIC
TAG	REGULATORY C	DR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			te survey ipleted)9/2012
NAME OF	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP CC WOODSTOCK DR	DE	
EASTER	R SEALS ARC OF I	NORTHEAST	FOR	T WAYNE, IN 46815		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE
W0149	-	R LSC IDENTIFTING INFORMATION)	IAG			DATE
VV0149	The facility must written policies a mistreatment, ne	MENT OF CLIENTS t develop and implement and procedures that prohibit eglect or abuse of the client.				
		d review and interview, the	W0149	<u>W149</u>		12/09/2012
	for the preventi and medication sampled clients he received his by his physician Findings includ The facility rec 11/1/12 at 8:00 Bureau of Deve Services (BDD			 The facility has policies procedures that prohibit mistreatment, neglect of the client. The nursing supervisor develop a procedure to medications ordered aft and/or needing authoriz payment to ensure time medication administration directed by client's physical the nursing supervisor all nursing staff on this provide the nursing supervisor monitor all medication of ensure timely delivery to the nursing supervisor monitor all medication of the nursing supervisor monitor medication of the nursing supervisor monitor medication of the nursing supervisor medication of the nursing supervisor medication of the nursing supervisor medicatication of the nursing supervisor medicatication of the nursi	r abuse of will procure er hours ation for ly on as sician. will train procedure. will yrders to	
	at 4:00 P.M. ind reports that on 9 a prescription f softener) after b nurse was notif permission if it drops ordered of the nursing sup given. On 9/17/ faxed to the pha approval from t	t dated 10/5/12 for 9/17/12 dicated "Nursing staff 9/14/12 [client C] received for Debrox ear drops (wax business hours. The on call fied and was asked was ok to get the ear on Monday 9/17/12 from ervisor. Permission was 1/2 the prescription was armacy and needed the nursing supervisor to ops. That same evening,		per physician orders. The Director of Resider Services will ensure this becomes a part of the F Department SOP. Nursing supervisor will in nursing staff on the requisite to report medication error Nursing supervisor will in new nursing staff and a staff annually. Note, the who reported the medici- late received disciplinar and is no longer with the	atial s policy Residential in-service uirements ors. train any Il nursing person ation error y action	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVCP11 Facility ID: 000713

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 15G180 11/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4420 WOODSTOCK DR EASTER SEALS ARC OF NORTHEAST FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG [name of group home] staff notified the Group home supervisor will nursing supervisor that the ear drops were in-service group home staff on not in the home. On 9/19/12 nursing staff medication procedure #17, notified the nursing supervisor about regarding getting paperwork from [client C's] needing his ear drops as he client appointments to the nurses as soon as possible or making had not yet received them. The nursing contact with the nurse as soon as supervisor stated she had contacted the possible. pharmacy and had faxed over the paper Person Responsible: Nursing regarding the ear drops. On 9/24/12supervisor, Group home nursing staff let the nursing supervisor supervisor and Director of know [client C] had never received his ear **Residential Services** drops and the pharmacy reported that the Completion Date: December 9, nursing supervisor had never called or 2012 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVCP11

Facility ID: 000713

If continuation sheet

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PRINTED:

11/30/2012

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION	(X3) DA COM	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 11/09/2012	
NAME OF	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZI	IP CODE		
EASTER	R SEALS ARC OF N	IORTHEAST		0 WOODSTOCK DR RT WAYNE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
	would not pay f nursing supervis securing payme Easter Seals AR pharmacy on 9/ not receive the f drops were deliv C] did receive h experience any						
	11/7/12 at 2:12 included a Reco Appointment da A.M The appo "Debrox 4 (four	inted 9/14/12 at 10:20 intment form indicated) drops both ear canals for raxno new changes					
	medication adm completed on 1 EMAR indicate	9/2012 EMAR (electronic inistration record) was 1/1/12 at 2:48 P.M The d client C received his os on 9/20/12, 9/21/12, 23/12.					
	10/9/12 was cor	facility internal cumentation dated npleted on 11/8/12 at e investigation summary					

	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	. ,	TE SURVEY IPLETED	
		15G180	A. BUILDING B. WING		- 11/0	11/09/2012	
NAME OF	PROVIDER OR SUPPLIE	ČR.	STREET	ODE			
EASTER	R SEALS ARC OF I	NORTHEAST		VOODSTOCK DR WAYNE, IN 46815			
X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	that [name of R warning for late standard discip written statement the incident ind -The written sta RN #1 indicate received a prese drops for wax r ears. The script nursing office w nurse was notif from staff at [m on-call nurse to it is only for ea can wait until M 9/17/12, the pre- was re-faxed ar non-covered m on the fax mach drops. The form RNS's] mailboo her approval. T notified the nur have the ear dro	atement dated 10/4/12 by d "On 9/14/12 [client C] cription for Debrox ear emoval for both of his was received after the vas closed and the on-call fied about the ear drops ame] group home. The ld the [GH] staff that since r drop removal, the drops Monday. On Monday escription for the ear drops					
	past 4 (four) da been held due t unavailable. I (pharmacy and s	ys, the medication had o the medication being RN #1) called [name] poke with someone in the department. I asked her					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ,	MULTIPLE CO	00	č - 1	ATE SURVEY MPLETED
		15G180	A. BUILDING				09/2012
NAME OF	AME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP	CODE	
EASTER	R SEALS ARC OF I	NORTHEAST		FORT V			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCET		DATE
	2	medication been sent and					
		responded that they never					
		al ok to bill facility or the					
	-	ay to bill the facility by					
		then emailed [name] RNS					
	-	20/12 regarding that [client					
		ive the ear drops and a med					
	· ,	ror form should be filled					
		nedication being started					
		ate. The response I					
		[name] RNS was that she					
		orm and spoke with the					
	· ·	she will look into it. I never					
		n [name] RNS if the ear					
	-	eived or not. I did check					
		[client C] received the ear					
	<u>^</u>	2-9/23/12, and no med					
	error form was	ever filled out."					
		atement dated 10/5/12 by					
		"On September 14th					
		a four day order for ear					
	-	e wax. It was ordered after					
		ay. The Residential					
	-) called on-call Friday and					
		vas ok to wait until					
	•	S) did not know anything					
		until 7:30 P.M. on					
	, ,	I received a text from					
		ng if they could start the					
		because they had not					
	-	s, assuming it was a new					
		nday, then she sent me a					
	text saying ther	e was an approval in my					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		UILDING	ONSTRUCTION 00	COM	DATE SURVEY DMPLETED 1/09/2012	
		15G180	B. W	/ING		11/		
NAMEOE	PROVIDER OR SUPPLIE	D		STREET	ADDRESS, CITY, STATE, ZIP	P CODE		
NAME OF	PROVIDER OR SUPPLIE	IK		4420 V	VOODSTOCK DR			
EASTER	R SEALS ARC OF N	NORTHEAST		FORT	WAYNE, IN 46815			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	OPPECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THI DEFICIENCY)		DATE	
	box for the drop	os. [Name] RN #1 never						
	told me she had	l stuck an approval in my						
		vork Tuesday signed the						
		illed the pharmacy to make						
		vould be sent to the house						
	-	n't hear anything Tuesday						
	-	so I assumed they were at						
		nesday night I received an						
		ne] RS saying that she still						
	-	d the drops. I called the						
		-						
		n on Thursday to have						
		lrops out. I asked [name]						
		ector (RD) if we could talk						
		d she feel like it was an						
		as four day wax removal						
	treatment. She	said she did not feel like it						
	was an error'	,						
	An interview w	as conducted with the						
	RNS on 11/1/12	2 at 3:02 P.M The RNS						
	stated, "The dro	ops did not arrive in the						
	home until the	20th. He missed the drops						
		nd 9/19. The doctor did						
		oblems and the pharmacy						
		y explanation why it was						
		7. The order was for only						
		e BDDS report it was not						
		9/24 because the order						
		en and discontinued by						
		d get it for four days 9/20,						
	9/21, 9/22 and 9							
	<i>5121, 5122</i> and 5	// 						
		as conducted with the RS 15 P.M The RS stated,						

TATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G180	A. BU B. WI	ILDING NG	00	COMPLETED - 11/09/2012	
			D. 111		ADDRESS, CITY, STATE, ZIP CODE		
IAME OF I	PROVIDER OR SUPPLIE	ER	4420 WOODSTOCK DR				
EASTER	SEALS ARC OF N	NORTHEAST	FORT WAYNE, IN 4681		VAYNE, IN 46815		
X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		,		TAG	DEFICIENCET		DATE
	-	axed it to nurse [Name of					
		armacy. It was after 4:00					
		(direct care staff at GH)					
		t, but they didn't. I did it					
	•	ork that day. Yes, it was a					
	morning appoir	itment."					
	An interview w	as conducted with the					
	Qualified Deve	lopmental Disabilities					
	Professional (Q	DDP) on 11/7/12 at 3:01					
	P.M The QDD	OP stated, "Normally we					
	fax to pharmac	y if no problem with					
	payment they w	vill deliver it at least by the					
	next day to the	house. Since it was a					
	morning appoir	ntment it would have					
	normally have l	been delivered that night. I					
	think if they ne	ed approval for payment					
	then the [name]	RD or [name] RNS must					
	authorize it to b	be sent."					
	An interview w	as conducted over the					
		12 at 11:06 A.M. with the					
	-	p homes. The RD stated,					
	-	system for medications					
		ours. If it is something the					
		n wait until Monday, they					
		day. If it is something that					
		e nurse gives authorization.					
		nent is practiced. If it is a					
		em they contact me.					
	• •	e is to fax the pharmacy,					
	-	als needed and start within					
		ormally any appointment					
	-	vithout medication changes					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION	(X3) DATE SUI COMPLET		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G180	A. BUILDING 00			11/09/2012		
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE					
					OODSTOCK DR			
EASTEF	R SEALS ARC OF N	NORTHEAST		FORT V	VAYNE, IN 46815			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI		DATE	
	-	on the next route. If it was						
		intment it should have						
		afternoon route that same						
	- ·	P.M.). We were not going						
	<u>^</u>	DDS because the						
		not in the house, it was						
		because it was not put in						
		did not deem it an						
		se it was a nursing						
	decision to wait	t until Monday."						
	The Medication	Procedures Policy dated						
	10/24/12 was re	eviewed on 11/8/12 at 1:15						
	-	edure indicated "17. All						
	paperwork from	n appointments shall be						
	returned to the	nursing department as						
	-	e on the same day of the						
		8. The nurse/supervisor						
	-	prescriptions to the						
		ALL MEDICATION						
		JST BE INITIATED						
		n, dropped off to						
	1 57	THIN 24 (twenty-four)						
	HOURS OF RE	ECEIVING A SCRIPT. If						
		or treatment has not						
		4 hours appropriate						
		must be completed stating						
	why."							
	The facility Sta	ndard Operating						
	Procedures / At	ouse and Neglect Policy						
		07 was reviewed on						
	11/8/12 at 11:42	2 A.M The policy						
		Abuse, neglect,						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	Ĩ.	LDING G	00		te survey Mpleted 109/2012
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP (OODSTOCK DR	CODE	
EASTER	R SEALS ARC OF I	NORTHEAST			VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	d mistreatment are					
	expressly forbid	ddenSuspected instances					
	of neglect, abus	se, exploitation, client					
	mistreatment or	any infractions of this					
	policy by staff	must be reported to the					
	Supervisor, Ma	nager, or President					
	immediately. T	his supervisor will then					
	report the alleg	ed violation(s) to the					
	client's legal rep	presentative if applicable					
	and to any othe	r person according to					
	BDDS regulation	ons when applicable.					
	Employees mus	st report suspected or					
	observed instan	ces of neglect, abuse, or					
	exploitationF	.) Medications and					
	treatments will	be administered as					
	specified by ph	ysician orders and as					
	taught in the 'L	iving in the Community'					
	Core A and Cor	re B it will be a					
	medication erro	or if medications and/or					
	treatments are r	not administered as					
	specified by the	e physician's					
		ation will be the result for					
	any of the follo	wing: 1. Intentionally					
	concealing a m	edication error or failing to					
	-	medication errorThe					
	-	ed Mental Retardation					
		ll submit a BDDS					
		rt 7 (seven) calendar days					
		ness days (whichever is					
	sooner) after th						
	An Interview	as conducted with the					
		Auditor (LIA) on 11/9/12 at					
	10.39 A.M. W	hen asked if the facility					

NTERS FC	R MEDICARE & MEDIC	AID SERVICES				(OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180		ILDING NG	00	COM 11/0	te survey 1pleted 09/2012	
NAME OF	PROVIDER OR SUPPLIE	2	STREET ADDRESS, CITY, STATE, ZIP CODE					
EASTEI	R SEALS ARC OF N	ORTHEAST			OODSTOCK DR VAYNE, IN 46815			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
	LIA stated, "The for reporting a n indicated she wa system was for o hours or authoriz medications. Th know the answe	ed the facility policies, the ey did not follow policy nedication error." The LIA as not sure what the ordering medications after zing payment for e LIA stated, "I do not r, I will need to look." relates to complaint						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOD MEDICADE & MEDICAID SEDVIC

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/09/2012
	PROVIDER OR SUPPLIE		4420 V	ADDRESS, CITY, STATE, ZIP CODE VOODSTOCK DR WAYNE, IN 46815	
(X4) ID PREFIX TAG V0153	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	The facility must of mistreatment, injuries of unknoi immediately to the officials in accord through establish Based on record facility staff fail medication erro for 1 of 3 sample neglecting to en- medication as o days, as indicated Developmental (BDDS) reports administrator an accordance with Findings includ The facility reco 11/1/12 at 8:00 Bureau of Deve Services (BDDS) until 11/1/12. T indicated: A BDDS report at 4:00 P.M. ind reports that on S a prescription for softener) after b	I review and interview, the led to immediately report a r (allegation of neglect) led clients (client C) by usure he received his rdered by physician for six ed in 1 of 16 Bureau of Disabilities Services reviewed, to the nd to other officials in n state law.	W0153	 W153 The facility has policies and procedures that prohibit mistreatment, neglect or abuse the client. The nursing supervisor will develop a procedure to procur medications ordered after hour and/or needing authorization for payment to ensure timely medication administration as directed by client's physician. The nursing supervisor will traiall nursing staff on this proced The nursing supervisor will monitor all medication orders to ensure timely delivery to client per physician orders. Nursing supervisor will in-servinursing staff on the requirement to report medication errors. Nursing supervisor will train ar new nursing staff and all nursing staff and all nursing staff and all nursing staff and all nursing staff annually. Note, the person who reported the medication error and is no longer with the agen. The Director of Residential 	e rs pr in ure. o s ice nts ice nts ny ng n n rror n

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVCP11

Facility ID: 000713

If continuation sheet Page 22 of 34

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A B	UILDING	00	COMPL	
		15G180		/ING		11/0)9/2012
			STREET ADDRESS, CITY, STATE, ZIP			DE	
NAME OF	PROVIDER OR SUPPLIE	.R		4420 V	VOODSTOCK DR		
EASTER	SEALS ARC OF N	NORTHEAST		FORT	WAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	permission if it	was ok to get the ear			Services will ensure this		
	drops ordered o	n Monday 9/17/12 from			becomes a part of the R	esidential	
	the nursing sup	ervisor. Permission was			Department SOP.		
	given. On 9/17/	12 the prescription was			Person Responsible: Nu	ursing	
	faxed to the pha	armacy and needed			supervisor and Director		
	-	he nursing supervisor to			Residential Services		
		ops. That same evening,			Completion Date: Decen	nber 9,	
		home] staff notified the			2012		
		sor that the ear drops were					
	• •	2. On 9/19/12 nursing staff					
		sing supervisor about					
		ding his ear drops as he					
		eived them. The nursing					
	-	ed she had contacted the					
	-						
		had faxed over the paper					
		ar drops. On 9/24/12					
	-	the nursing supervisor					
		had never received his ear					
		harmacy reported that the					
		sor had never called or					
		tter confirming payment					
	-	. This incident is					
		e an allegation of neglect.					
		pervisor involved in this					
		of RNS] has been					
	suspended pend	ling the outcome of an					
	investigation. N	lursing staff report that					
	[client C] does	not appear to have					
	suffered any ne	gative outcomes as a result					
	of his missed ea	ar drops." The BDDS					
		submitted until 10/5/12 for					
	the 9/17/12 med						
	An interview w	as conducted over the					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	INSTRUCTION	(X3) DA'	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COM	IPLETED	
		15G180	B. WI			11/09/2012		
				STREET A	ADDRESS, CITY, STATE, ZIP	P CODE		
NAME OF	PROVIDER OR SUPPLIE	R		4420 W				
EASTEF	R SEALS ARC OF N	IORTHEAST		FORT V	VAYNE, IN 46815			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	EAPPROPRIATE	DATE	
	phone on 11/9/1	2 at 11:06 A.M. with the						
	RD of the grou	p homes. The RD stated,						
		going to report it to						
		the medication was not in						
		s not an omission because						
		the EMAR. We did not						
	-	sion because it was a						
		n to wait until Monday."						
		i to wait antir Monday.						
	An Interview w	as conducted with the						
		uditor (LIA) on 11/9/12 at						
		nen asked if the facility						
		ed the facility policies, the						
		ey did not follow policy						
		nedication error." The LIA						
		edication error had been						
	reported late.							
		• • • • • •						
	-	g relates to complaint						
	#IN00117768.							
	9-3-2(a)							

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G180 11/09/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4420 WOODSTOCK DR EASTER SEALS ARC OF NORTHEAST FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE W0331 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. W0331 12/09/2012 Based on record review and interview, the W331 facility nursing staff failed to ensure 1 of The nursing supervisor will 3 sampled clients (client C) received his develop a procedure to procure medication when ordered by his medications ordered after hours physician. and/or needing authorization for payment to ensure timely medication administration as Findings include: directed by client's physician. The facility records were reviewed on The nursing supervisor will train all nursing staff on this procedure. 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities The nursing supervisor will Services (BDDS) reports from 11/21/11 monitor all medication orders to until 11/1/12. The BDDS reports ensure timely delivery to clients per physician orders. indicated: The Director of Residential A BDDS report dated 10/5/12 for 9/17/12 Services will ensure this policy at 4:00 P.M. indicated "...Nursing staff becomes a part of the Residential Department SOP. reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax Person Responsible: Nursing softener) after business hours. The on call supervisor and Director of nurse was notified and was asked **Residential Services** Completion Date: December 9, permission if it was ok to get the ear 2012 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LVCP11

Facility ID: 000713

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	MULTIPLE CC JILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2012	
		15G180	A. DU B. W.				
					ADDRESS, CITY, STATE,	ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	SK		4420 W	OODSTOCK DR		
EASTER	SEALS ARC OF I	NORTHEAST		FORT V	VAYNE, IN 46815		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIEN	CY)	DATE
		sing supervisor about					
		ding his ear drops as he					
	-	eived them. The nursing					
	-	ed she had contacted the					
	1 5	had faxed over the paper					
		ar drops. On 9/24/12					
	•	t the nursing supervisor					
		had never received his ear					
		harmacy reported that the					
		sor had never called or					
		tter confirming payment					
		. This incident is					
		e an allegation of neglect.					
		pervisor involved in this					
	-	of RNS] has been					
		ling the outcome of an					
		lursing staff report that					
		not appear to have					
		gative outcomes as a result					
	of his missed ea	ar drops."					
	A BDDS follow	v up report dated 10/10/12					
	indicated "An i	nvestigation into this					
	matter was con-	ducted and the results were					
	presented to the	e Easter Seals ARC abuse					
	and neglect con	nmittee. The abuse and					
	-	tee found that the					
	allegation of ne	glect was not					
	substantiated. C	On 9/17/12 the ear drops					
		om the pharmacy. On					
	-	rmacy alerted the nursing					
	-	[client C's] insurance					
		for the ear drops. The					
	nursing supervi	sor completed the forms					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G180 11/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4420 WOODSTOCK DR EASTER SEALS ARC OF NORTHEAST FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 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

11 Facility ID: 000713

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO		· · ·	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G180	A. B	UILDING	00			
		15G180	B. W	ING		11/09/2012		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZI	P CODE		
			4420 WOODSTOCK DR					
EASTER	SEALS ARC OF N	NORTHEAST		FORTV	VAYNE, IN 46815			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY))	DATE	
	morning appoin	itment."						
		as conducted with the						
		2 at 3:02 P.M The RNS						
	stated, "The dro	pps did not arrive in the						
		20th. He missed the drops						
	on 9/17, 9/18, a	nd 9/19. The doctor did						
	not have any pr	oblems and the pharmacy						
	did not give any	explanation why it was						
	not sent on 9/17	7. The order was for only						
	four days. In the	e BDDS report it was not						
	in the house on	9/24 because the order						
	was already giv	en and discontinued by						
	that date. He die	d get it for four days 9/20,						
	9/21, 9/22 and 9	9/23."						
	An interview w	as conducted with the						
	Qualified Deve	lopmental Disabilities						
	Professional (Q	DDP) on 11/7/12 at 3:01						
	P.M The QDD	PP stated, "Normally we						
	-	y if no problem with						
		vill deliver it at least by the						
		house. Since it was a						
	-	tment it would have						
		been delivered that night. I						
	-	ed approval for payment						
	-	RD or [name] RNS must						
	authorize it to b							
		e sent.						
	An interview w	as conducted over the						
		12 at 11:06 A.M. with the						
	-							
	-	p homes. The RD stated,						
		system for medications						
	ordered after ho	ours. If it is something the						

TEKS FU	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE CO	(X3) DAT	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BI	a. Building 00			COMPLETED	
		15G180	А. В. В. W			11/0	9/2012	
			D. 11		ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF	PROVIDER OR SUPPLIE	R		4420 W				
EASTEF	R SEALS ARC OF N	IORTHEAST			VAYNE, IN 46815			
(X4) ID	SUMMADVS	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	DATE	
	nurse deems can wait until Monday, they							
		lay. If it is something that						
		nurse gives authorization.						
		ent is practiced. If it is a						
		em they contact me.						
	-	e is to fax the pharmacy,						
		ls needed and start within						
	-	ormally any appointment						
	forms with or w	ithout 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							
		DDS because the						
	-	not in the house, it was						
		because it was not put in						
		did not deem it an						
		se it was a nursing						
	decision to wait	unui Monday."						
	This Federal tag	g relates to complaint						
	#IN00117768.							
	9-3-6(a)							

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G180 11/09/2012 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4420 WOODSTOCK DR EASTER SEALS ARC OF NORTHEAST FORT WAYNE. IN 46815 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 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. W0368 Based on record review and interview, the 12/09/2012 W368 facility failed to assure all medications The nursing supervisor will were administered in compliance with the develop a procedure to procure physician's order for 1 of 3 sampled medications ordered after hours clients (client C). and/or needing authorization for payment to ensure timely medication administration as Findings include: directed by client's physician. The facility records were reviewed on The nursing supervisor will train all nursing staff on this procedure. 11/1/12 at 8:00 A.M. including the Bureau of Developmental Disabilities The nursing supervisor will Services (BDDS) reports from 11/21/11 monitor all medication orders to until 11/1/12. The BDDS reports ensure timely delivery to clients per physician orders. indicated: The Director of Residential A BDDS report dated 10/5/12 for 9/17/12 Services will ensure this policy at 4:00 P.M. indicated "...Nursing staff becomes a part of the Residential Department SOP. reports that on 9/14/12 [client C] received a prescription for Debrox ear drops (wax Person Responsible: Nursing softener) after business hours. The on call supervisor and Director of nurse was notified and was asked **Residential Services** Completion Date: December 9, permission if it was ok to get the ear 2012 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

Facility ID: 000713

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	00			COMPLETED	
	15G180		A. BUI B. WIN	LDING		11/09/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
IAME OF	PROVIDER OR SUPPLIE	R			OODSTOCK DR		
EASTEF	R SEALS ARC OF N	NORTHEAST			VAYNE, IN 46815		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
REFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	RIATE	PLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	D	ATE
		. On 9/19/12 nursing staff					
		sing supervisor about					
		ling his ear drops as he					
		eived them. The nursing					
	supervisor state	d she had contacted the					
	pharmacy and h	ad 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 pl	harmacy reported that the					
	nursing supervi	sor had never called or					
	sent back the le	tter confirming payment					
	for the delivery	. This incident is					
	considered to be	e an allegation of neglect.					
	The nursing sup	pervisor involved in this					
	• •	of RNS] has been					
	-	ling the outcome of an					
		ursing staff report that					
		not appear to have					
		gative outcomes as a result					
	of his missed ea						
	A BDDS follow	v up report dated 10/10/12					
		nvestigation into this					
		lucted and the results were					
		Easter Seals ARC abuse					
	-	mittee. The abuse and					
	-	tee found that the					
	allegation of ne						
	-	On $9/17/12$ the ear drops					
		om the pharmacy. On					
		rmacy alerted the nursing					
	-						
	-	[client C's] insurance					
	would not pay f	or the ear drops. The					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		MULTIPLE C	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	СО	COMPLETED	
		15G180		UILDING /ING		— 11.	/09/2012	
			D. W		ADDRESS, CITY, STATE, Z	 IP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			NOODSTOCK DR			
FASTER	R SEALS ARC OF I	NORTHEAST			WAYNE, IN 46815			
					,coo		(272)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO		(X5) COMPLETIC	
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE	
TAU		,		IAU		,	DATE	
	• •	sor completed the forms						
		ent to the pharmacy from						
		RC 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 deli	vered on 9/19/12. [Client						
	C] did receive l	his ear drops and did not						
	-	adverse affects from the						
		yment issues. His doctor						
	was notified an	•						
	recommendatio							
	recommendatio	115.						
	Climet Classes	1						
		d was reviewed on						
		P.M. Client C's record						
	included a Reco							
	Appointment da	ated 9/14/12 at 10:20						
	A.M The appo	pintment form indicated						
	"Debrox 4 (fou	r) drops both ear canals for						
	4 days for ear w	vaxno new changes						
	other than Debi	-						
	A review of the	9/2012 EMAR (electronic						
		ninistration record) was						
		,						
	-	1/1/12 at 2:48 P.M The						
		ed client C received his						
		ps on 9/20/12, 9/21/12,						
	9/22/12, and 9/2	23/12.						
	An interview w	as conducted with the						
	RNS on 11/1/12	2 at 3:02 P.M The RNS						
	stated, "The dro	ops did not arrive in the						
		20th. He missed the drops						
		.nd $9/19$. The doctor did						
		oblems and the pharmacy						
	I not nut o uny pr	continuo una una priurmacy			1			

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE CO	ONSTRUCTION	(X3) DA	OMB NO. 0938-03 TE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			00		COMPLETED	
		15G180	A. BU B. WI	JILDING NG		- 11/	09/2012	
	PROVIDER OR SUPPLI	ED			ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF	PROVIDER OR SUPPLI	EK			/OODSTOCK DR			
EASTER	R SEALS ARC OF	NORTHEAST		FORT	WAYNE, IN 46815			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETI	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	-	y explanation why it was						
		7. The order was for only						
		e BDDS report it was not						
		9/24 because the order						
		ven and discontinued by						
	that date. He di	d get it for four days 9/20,						
	9/21, 9/22 and	9/23."						
	An interview w	vas conducted over the						
		12 at 11:06 A.M. with the						
	-	up homes. The RD stated,						
	-	system for medications						
		ours. If it is something the						
		in wait until Monday, they						
		day. If it is something that						
		e nurse gives authorization.						
		nent is practiced. If it is a						
		lem they contact me.						
		e is to fax the pharmacy,						
	-	als needed and start within						
		formally any appointment						
	1 7	vithout medication changes						
		on the next route. If it was						
	-	bintment it should have						
		afternoon route that same						
		P.M.). We were not going						
	-	BDDS because the						
		s not in the house, it was						
	not an omission because it was not put in the EMAR. We did not doom it on							
	the EMAR. We did not deem it an							
		ise it was a nursing						
	decision to wai	t until Monday."						
	This Federal ta	g relates to complaint						
		•						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/09/2012	
				ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF 1	PROVIDER OR SUPPLIE	.K		/OODSTOCK DR		
EASTER	SEALS ARC OF N	NORTHEAST	FORT	WAYNE, IN 46815		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	#IN00117768.					
	9-3-6(a)					