

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G751	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2015
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 HAFFNER DR FORT WAYNE, IN 46835
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(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
W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: May 20, 21 and 22, 2015.</p> <p>Facility number: 011870 Provider number: 15G751 AIM number: 200912390</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed to ensure facility owned day program staff followed the behavior</p>	W 0249	The workshopstaff will be retrained on client #3's behavior support plan	06/19/2015

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>support plan for 1 of 1 sampled client who had a behavior support plan (client #3).</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/20/15 at 2:13 P.M. including an ABC(antecedent/behavior/consequence) Behavior Tracking form dated 3/31/15 at 9:00 A.M. indicated the following: "[Client #3] began targeting a peer for 'laughing.' [Client #3] was asked to stop and continue working on paid work. [Client #3] stopped, then chose to target another peer yelling at them to hurry up and get their parts faster. [Client #3] was told by staff she would not be able to have her tea for lunch. [Client #3] began crying and yelling, sticking her tongue out at staff, cursing at staff etc. Staff let [client #3] calm down. [Client #3] came up to staff later and apologized. Later at the end of the day. [Client #3] started again on targeting a peer for 'laughing.' She (client #3) began yelling at cursing at (sic) the peer so staff told her no tea for tomorrow. She began yelling and crying towards staff (sic) until her ride picked her up."</p> <p>Client #3's record was reviewed on 5/21/15 at 3:04 P.M. Client #3's record indicated she had a Behavior Support</p>		<p>PersonResponsible: Behavior Consultant DateCompleted: June 19, 2015</p> <p>Client 3'sbehavior consultant will conduct a weekly observation of client # 3's workshoparea for one month checking for adherence to the BSP. The observations will bedocumented and any issues noted will be corrected</p> <p>PersonResponsible: Behavior Consultant CompletionDate: June 19, 2015</p> <p>The QIDP willconduct weekly observations of the workshop for one month checking foradherence to all clients' BSPs. The QIDP will conduct observations of theworkshop quarterly on an ongoing basis. The observations will be documented andany issues noted will be corrected.</p> <p>PersonResponsible: QIDP CompletionDate: June 19, 2015</p> <p>-</p>				

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	<p>Plan (BSP) dated 3/15/15 which included interventions to assist client #3 in reducing the following behaviors: "Disruptive Behaviors: yelling, name calling, unkind comments to others and bossing others, [Client #3] will decide her peers actions are wrong, and she will yell or make negative comments to them." Client #3's BSP indicated if disruptive behavior occurs: staff were to</p> <ol style="list-style-type: none"> 1. Remind her to Stop-Think and Make a Good Choice. 2. If she stops, ask her what is upsetting her and assist with conflict resolution. 3. If she continues to be disruptive, ignore the behavior. 4. Once she is calm, have her return back to activity. 5. Assist her with conflict resolution when calm. <p>The Residential Director (RD) was interviewed on 5/22/15 at 11:25 A.M. When asked if staff had followed client #3's BSP, the RD stated, "No, staff should have reminded her to stop, assisted her with conflict resolution, ignore the behavior if it continued and then redirect her to another activity. The tea is a reinforcer so staff should not have told her she couldn't have it. The staff have been trained on her BSP."</p> <p>9-3-4(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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