STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G075	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTER SEALS ARC OF NORTHEAST	4422 LAKE AVE 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
W000000	This visit was for a pre-determined full annual recertification and state licensure survey. Dates of Survey: April 23, 24, 25 and 26, 2013. Facility number: 000619 Provider number: 15G075 AIM number: 100233750 Surveyor: Kathy Wanner, QIDP. The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed May 2, 2013 by Dotty Walton, QIDP.	W000000		

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

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.

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W000104	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 general policy, budget and operating direction over the facility for 3 of 4 sampled clients (clients #2, #3 and #4), and for 1 of 4 additional clients (client #7), by failing to ensure clients did not pay for their haircuts from their own personal funds instead of being provided by the facility. Findings include: Client financial records were reviewed on 4/25/13 at 11:00 A.M. and indicated the following: Client #2's financial record indicated client #2 had paid for a manicure and haircut at a local beauty college on 3/13/13 for a total of $11.00. Client #3's financial record indicated client #3 had paid for a manicure and haircut at a local beauty college on 3/13/13 for a total of $11.00 including tip. Client #4's financial record indicated client #4 had paid for a manicure and haircut at a local beauty college on 3/13/13 for a total of $13.00 including tip.	W000104	W104 For clients #2, #3, #4 and #7 the agency will reimburse each client for the cost of the haircut. Person Responsible: Client financial specialist Completion Date: May 26, 2013 Residential staff will be in-serviced on per diem standards. Person Responsible: QIDP Completion Date: May 26, 2013 Ongoing, to ensure compliance for all clients, the business office will review the client receipts to make sure clients have not been paying for items that are in the per diem rate. Any items found to have been paid for that are included in the per diem rate will be reimbursed. Receipts will be reviewed by the business office, client financial specialist, to ensure items are not purchased by individuals that should have come from the per diem. Person Responsible: Client financial specialist Completion Date: May 26, 2013	05/26/2013

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	Client #7's financial record indicated client #7 had paid for a manicure and hairdo/haircut at a local beauty college on 3/13/13 for a total of $11.00. An interview with the facility Client Financial Specialist (CFS) was conducted on 4/25/13 at 11:40 A.M. When asked about the clients paying for their own haircuts, the CFS stated, "If they actually did pay for the haircuts we would pay them back." The CFS indicated she was not sure if the haircuts/hairdos were for routine haircuts or for a special event/occasion. An interview with Direct Support Staff (DCS) #2 was conducted on 4/26/13 at 7:08 A.M. DCS #2 indicated she had taken clients #2, #4, and #7 to the beauty college for their manicures and haircuts. DCS #2 indicated the clients were in need of haircuts and they were not completed for a special occasion or anything other than a normal haircut. DCS #2 indicated another staff had taken client #3 and client #3 had received a normal routine haircut. 9-3-1(a)			

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W000368	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, observation and interview the facility failed to ensure 1 of 4 additional clients (client #5) was administered his medications in compliance with his physician's orders. Findings include: A Bureau of Developmental Disabilities Services (BDDS) report dated 4/24/13 for an incident on 4/13/13 at 6:00 A.M. was reviewed on 4/25/13 at 11:45 A.M. The BDDS report indicated "[Client #5]...recently diagnosed condition, Bollous (sic) Pemphigold (blisters and ulcers), an autoimmune disorder of the skin. He was prescribed predisone (sic) (steroid) to help this condition. He was to start 30 mg (thirty milligrams) of prednisone on 4/13, for five days, then taper to 20 mg (twenty milligrams) for five days, then 10 mg (ten milligrams) for five days. On 4/23/13 it was reported that he was out of predinisone (sic). He should have had enough to take through 4/27/13. Upon investigation it appears that the staff on 4/13/13 gave two doses (60 mg, six 10 mg tabs total) and did not mark these. Then, the staff on 4/18 continued to give three tabs instead of two because	W000368	W368 The facility has policies and procedures to ensure all medications are administered in compliance with the physician's orders. Residential supervisor will complete a supervised medication pass on all residential DSP's at this group home and quarterly on-going to ensure all medications are administered in compliance with physician orders. Person Responsible: Residential Supervisor Completion Date: May 26, 2013 Agency nurse will retrain all house staff on proper medication administration. Person Responsible: Agency nurse Completion Date: May 26, 2013	05/26/2013

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	they did not understand that the 4/13 dose had been given. This led to [client #5] being four doses short. The doctor was contacted a (sic) on the evening of 4/13/13 when the error was discovered. On 4/24/13 the doctor ordered [client #5] a new package of predinose (sic) and asked that it be started on 4/24/13, to be completed after 15 (fifteen) days. There does not appear to be any adverse side effects from this error. Staff will receive retraining. The packages for the prednisone have been clearly labeled as to which pills should be given each day." Observations at the group home were conducted on 4/25/13 from 6:06 A.M. through 7:08 A.M. At 6:18 A.M. a Prednisone instruction sheet posted in the medication room was reviewed and indicated "Prednisone Instructions for 4/24- 5/8 (2013): 3 (three) pills 4/24, 4/25, 4/26, 4/27, 4/28: 2 (two) pills 4/29, 4/30, 5/1, 5/2, 5/3: 1 (one) pill 5/4, 5/5, 5/6, 5/7 and 5/8." The Group Home Manager (HM) was interviewed on 4/23/13 at 4:50 P.M. The HM indicated client #5 had been having an issue with a skin condition which had covered most of his body with blisters. The HM stated, "He has been prescribed prednisone to help with the rash."			

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	A facility Qualified Intellectual Disabilities Professional (QIDP) #2 was interviewed on 4/26/13 at 11:20 A.M. QIDP #2 stated, "Yes, his medication should have been passed according to his physician's orders." 9-3-6(a)			