

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 the pre-determined full annual recertification and state licensure survey.</p> <p>Survey Dates: 3/28, 3/29, 3/30, 3/31, and 4/6/23.</p> <p>Facility Number: 011871 Provider Number: 15G752 AIMS Number: 200921870</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #27547 on 4/21/23.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 3 sampled clients (#1 and #2) plus 2 additional clients (#4 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients #1, #2, #4, and #6 did not pay for haircuts and doctor's bills.</p> <p>Findings include:</p> <p>Client Financials were reviewed on 3/30/23 at 1:22 PM and 3/31/23 at 10:33 AM and indicated the following:</p> <p>1. Client #1's 1/2023 General Ledger (GL) indicated client #1 paid \$17 to [name of optical repair office] on 1/18/23.</p>	W 0104	<p>W104</p> <p>Client #1 was reimbursed \$17 for the payment made on 1/18/23 to [name of optical repair office]. Client #1 was reimbursed \$23 for the payment made on 12/19/22 for a haircut. Client #1 was reimbursed \$30 for the payment made in 12/2022 to [name of dental facility]. Client #1 was reimbursed \$23 for the payment made on 8/29/22 for a haircut. Totaling \$93.00 that Client #1 was reimbursed by the agency. Client #2 was reimbursed \$20 for the payment made on 8/29/22 for a haircut. Client #2 was</p>	05/05/2023

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

TITLE

(X6) DATE

Katlyn Rife

Director of Group Homes

05/05/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>Client #1's 12/2022 Bank Statement (BS) indicated client #1 paid \$23 on 12/19/22 for a haircut. Client #1's 12/2022 GL indicated client #1 paid \$30 to [name of dental facility].</p> <p>Client #1's 8/2022 BS indicated client #1 paid \$23 on 8/29/22 for a haircut.</p> <p>2. Client #2's 8/2022 BS indicated client #2 paid \$20 on 8/29/22 for a haircut.</p> <p>Client #2's 7/2022 BS indicated client #2 paid \$18 on 7/11/22 for a haircut.</p> <p>3. Client #4's 2/2023 BS indicated client #4 paid \$18 on 2/6/23 for a haircut.</p> <p>Client #4's 1/2023 GL indicated client #4 paid \$77.75 to [name of dental facility].</p> <p>Client #4's 12/2022 BS indicated client #4 paid \$23 on 12/19/22 for a haircut.</p> <p>Client #4's 10/2022 BS indicated client #4 paid \$21 on 10/11/22 for a haircut.</p> <p>Client #4's 8/2022 BS indicated client #4 paid \$23 on 8/29/22 for a haircut.</p> <p>Client #4's 7/2022 BS indicated client #4 paid \$18 on 7/11/22 for a haircut.</p> <p>4. Client #6's 1/2023 GL indicated client #6 paid \$50 two separate times (1/18/23 and 1/24/23) for a total of \$100 to [name of Primary Care Physician (PCP)].</p> <p>Client #6's 12/2022 GL indicated client #6 paid \$50 on 12/14/22 to [name of PCP].</p> <p>Client #6's 8/2022 BS indicated client #6 paid \$23 on 8/29/22 for a haircut.</p> <p>The Client Financial Supervisor (CFS) was interviewed on 3/31/23 at 12:30 PM. The CFS indicated he was unaware of what the facility covers for clients who live in the group home.</p>		<p>reimbursed \$18 for the payment made on 7/11/22 for a haircut. Totaling \$38.00 that Client #2 was reimbursed by the agency.</p> <p>Client #4 was reimbursed \$18 for the payment made on 2/6/23 for a haircut. Client #4 was reimbursed \$77.75 for the payment made in 1/2023 to [name of dental facility]. Client #4 was reimbursed \$23 for the payment made on 12/19/22 for a haircut. Client #4 was reimbursed \$21 for the payment made on 10/11/22 for a haircut.</p> <p>Client #4 was reimbursed \$23 for the payment made on 8/29/22 for a haircut. Client #4 was reimbursed \$18 for the payment made on 7/11/22 for a haircut. Totaling 180.75 that Client #4 was reimbursed by the agency.</p> <p>Client #6 was reimbursed \$100 for two separate \$50 payments made on 1/18/23 and 1/24/23 to [name of Primary Care Physician (PCP)]. Client #6 was reimbursed \$50 for the payment made on 12/14/22 to [name of PCP]. Client #6 was reimbursed \$23 for the payment made on 8/29/22 for a haircut. Totaling \$152 that Client #6 was reimbursed by the agency.</p> <p>The facility will ensure that clients do not pay for haircuts or doctor's bills unless they have a liability. If a client has a liability, the Client Financial Supervisor will request that the liability be decreased by the amount of the medical bill and then the bill will be paid by the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated the facility should pay for haircuts and any charges at the doctors which isn't covered by their insurance.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated the facility should pay for haircuts and any charges their insurance does not cover at the doctor's office.</p> <p>The facility's undated Per Diem Policy was reviewed on 3/31/23 at 1:00 PM and indicated "ESARC (Easter Seals Arc) Group Home Per Diem Standards:</p> <p>The facility will provide each client with the following items which should not exceed the listed price (Please note if the want of the client exceeds the standard per diem rate the client may purchase the items with their own funds):</p> <p>Mattress and Box Spring \$450 Metal Bed Frame \$50 Mattress Cover \$70 Comforter \$50 Sheets \$40 Pillows \$12.00 Towels \$10.00 Wash Cloths \$4.00 Hand Towels \$5.00 Dresser \$325.00 Nightstand \$100.00 Hamper \$15.00</p> <p>Per ICFMR (Intermediate Care Facility Mental Retardation) guidelines the facility must also provide the following items:</p>		<p>client. If the client does not have a liability then the agency will pay their medical bills.</p> <p>Person Responsible: Client Financial Supervisor</p> <p>Date Completed: 5/5/2023</p> <p>The Client Financial Supervisor and Director of Group Homes will meet monthly for three consecutive months to audit Group Home clients financial statements in order to ensure that no clients pay directly for haircuts and doctor's bills. The Client Financial Supervisor and Director of Group Homes will ensure during the audit that expenses were paid using the method above for the clients that have a liability, and that the agency pays for medical bills for those who do not have a liability. Ongoing, the Client Financial Supervisor will audit group home clients financial statements quarterly to ensure that no clients pays directly for haircuts or doctor's bills. The Client Financial Supervisor will ensure during the audit that expenses were paid using the method above for the clients that have a liability, and that the agency pays for medical bills for those who do not have a liability.</p> <p>Persons Responsible: Client Financial Supervisor and Director of Group homes</p> <p>Date Completed: 5/5/2023</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0140 Bldg. 00	<p>*Haircuts (If the client requests an additional service such as a perm and or a color this would be at the client's expense).</p> <p>*Personal hygiene items (some examples of this would include deodorant, body wash, toothpaste, body spray and shampoo/conditioner).</p> <p>*Dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client.</p> <p>*Three meals daily (in and out of the facility). Using the client's funds for the purpose of going out to eat shall only be used when a meal is still being provided in the home but the client would prefer to eat out instead. If all clients in the home eat outside of the facility for a particular meal the client's funds are NOT to be used."</p> <p>9-3-1(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to ensure financial ledgers with receipts were available for review.</p> <p>Findings include:</p> <p>Client Financials were reviewed on 3/30/23 at 1:22 PM and 3/31/23 at 10:33 AM and indicated the following:</p>		W 0140	<p>W140</p> <p>The Group Home Supervisor will meet with the Client Financial Specialist monthly to review the ledger and receipts for expenses made by each consumer to ensure financial ledgers with receipts are completed. Ongoing, the Client Financial Specialist will review the account transactions quarterly to ensure that financial</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0149	<p>1. Client #1's 1/2023 BS (Bank Statement) indicated client #1 made 4 purchases during the month of January 2023. The facility was unable to provide receipts for the January 2023 purchases during the survey.</p> <p>Client #1's 2/2023 BS indicated client #1 made 3 purchases during the month of February 2023. The facility was unable to provide receipts for the February 2023 purchases during the survey.</p> <p>2. Client #2's 2/2023 BS indicated client #2 made 1 purchase during the month of February 2023. The facility was unable to provide a receipt for the February 2023 purchase during the survey.</p> <p>3. Client #3's 2/2023 BS indicated client #3 made 1 purchase during the month of February 2023. The facility was unable to provide a receipt for the February 2023 purchase during the survey.</p> <p>The Client Financial Supervisor (CFS) was interviewed on 3/31/23 at 12:30 PM. The CFS indicated receipts should be turned in so the clients' purchases can be reviewed.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated receipts should be turned in monthly for each client.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated receipts should be turned in monthly for each client.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p>		<p>ledgers with receipts match the transactions made according to the bank statements.</p> <p>Persons Responsible: Group Home Supervisor and Client Financial Specialist Date Completed: 5/5/2023</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
Bldg. 00	<p>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 for 2 of 3 sampled clients (#1 and #3) plus 1 additional client (#6), the facility failed to ensure their ANE (Abuse, Neglect, and Exploitation) Policy and Procedure was implemented to ensure clients #1, #3, and #6 were not exploited by staff earning retail store credit when the clients shopped in the community with their own money.</p> <p>Findings include:</p> <p>Client Financials were reviewed on 3/30/23 at 1:22 PM and 3/31/23 at 10:33 AM and indicated the following:</p> <p>1. Client #1's 12/2022 Bank Statement indicated client #1 went shopping at [name of retail store] on 12/22/22 and spent \$138.42. The retail store receipt indicated "[Former employee], Thanks for being a [retail store's] rewards member! \$20 [retail store's] cash activated ...\$10 earned for every \$50 purchased. [Retail Store's] rewards \$34.41 Updated balance. \$27.94 Previous Balance. \$6.47 earned on this purchase. Your [retail store's] rewards balance is converted and issued in \$5 increments on the first of the following month ...We'll track your [retail store's] cash so you don't have to. View your wallet in the [retail store's] app (application)."</p> <p>2. Client #3's 12/2022 Bank Statement client #3 went shopping at [name of retail store] on 12/23/22 and spent \$138.42. The retail store receipt indicated "[Former employee], Thanks for being a [retail store's] rewards member! \$20 [retail store's] cash activated ...\$10 earned for every \$50 purchased. [Retail Store's] rewards \$16.43</p>	W 0149	<p>W149</p> <p>All House Staff will be retrained on Easterseals Arc's Reporting and Investigation Allegations of Participant Abuse, Neglect, and Exploitation Policy and Procedure in order to ensure all clients are not exploited by staff earning retail store credit when the clients shopping in the community with their own money.</p> <p>Person Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The Client Financial Supervisor and Director of Group Homes will meet monthly for three consecutive months to review the Group Home clients receipts to ensure that clients are not exploited by staff earning retail store credit when the clients shopped in the community with their own money. Ongoing, the Client Financial Supervisor will review the Group Home clients quarterly to ensure that clients are not exploited by staff earning retail store credit when the clients shopped in the community with their own money.</p> <p>Persons Responsible: Client Financial Supervisor and Director of Group Homes</p> <p>Date Completed: 5/5/2023</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>Updated balance. \$10.65 Previous Balance. \$5.78 earned on this purchase. Your [retail store's] rewards balance is converted and issued in \$5 increments on the first of the following month ...We'll track your [retail store's] cash so you don't have to. View your wallet in the [retail store's] app (application)."</p> <p>3. Client #6's 12/2022 Bank Statement client #6 went shopping at [name of retail store] on 12/22/22 and spent \$246.22. The retail store receipt indicated "[Former employee], Thanks for being a [retail store's] rewards member! \$40 [retail store's] cash activated ...\$10 earned for every \$50 purchased. [Retail Store's] rewards \$22.16</p> <p>Updated balance. \$10.65 Previous Balance. \$11.51 earned on this purchase. Your [retail store's] rewards balance is converted and issued in \$5 increments on the first of the following month ...We'll track your [retail store's] cash so you don't have to. View your wallet in the [retail store's] app (application)."</p> <p>The Client Financial Supervisor (CFS) was interviewed on 3/31/23 at 12:30 PM. The CFS stated the former staff member earning [retail store] cash and rewards would "absolutely" be considered exploitation of the clients. The CFS indicated the clients should be able to use the cash and rewards for their own personal items.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH stated "it would be considered exploitation" for staff to earn rewards from a store based on a client's purchase.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated it would be considered</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0159 Bldg. 00	<p>exploitation for a staff member to earn rewards at a store based on a client's purchase.</p> <p>The facility's 4/8/19 Reporting and Investigation Allegations of Participant Abuse, Neglect or Exploitation Policy and Procedure was reviewed on 3/30/23 at 1:45 PM. The 4/8/19 Policy and Procedure indicated "... Exploitation includes but is not limited to: running personal errands while billing for a participant, falsifying time, and borrowing items from a participant...".</p> <p>9-3-2(a)</p> <p>483.430(a) QIDP</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the QIDP failed to ensure monthly reviews of the clients' program plan objectives were completed for clients #1, #2, and #3.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Client #1's record was reviewed on 3/29/23 at 9:37 AM. Client #1's record did not indicate monthlies had been completed for client #1 since October 2022. 2. Client #2's record was reviewed on 3/30/23 at 2:21 PM. Client #2's record did not indicate monthlies had been completed for client #2 since October 2022. 3. Client #3's record was reviewed on 3/30/23 at 2:50 PM. Client #3's record did not indicate 	W 0159	<p>W159</p> <p>All monthly reviews of the client's program plan objectives have since been completed for November 2022-Current. The QIDP will meet with Director of Group Homes monthly for three consecutive months to review the QIDP's schedule and workload, in order to ensure time is being set aside to complete monthly reviews. Ongoing, if the monthly reviews are not turned within 5 business days of the due date, the QIDP will meet with the Director of Group Homes to review the QIDP's schedule and workload, in order to ensure time is being set aside to complete monthly reviews of the clients' program plan</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PARTICULARS PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0189 Bldg. 00	<p>monthlies had been completed for client #3 since October 2022.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated monthlies should be completed every month for each client to review goal progress.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP stated she "had not had time to complete to monthlies due to having other duties and sometimes I don't have time." The QIDP indicated monthlies should be completed every month for each client to assess progress or regression on their goals.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review, and interview for 1 of 3 sampled clients (#2), the facility failed to ensure staff were trained and competent in administering medications to client #2 and reporting an unknown injury.</p> <p>Findings include:</p> <p>1. Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:32 AM, staff #3 noticed client #2 had a bump on his forehead with redness around it. Staff #3 indicated she did not know how he got the bump on his head. Staff #3 asked staff #1 if she had seen client #2 hit his head. Staff #1 indicated she</p>	W 0189	<p>objectives.</p> <p>Persons Responsible: QIDP and Director of Group Homes</p> <p>Date Completed: 5/5/2023</p> <p>W189</p> <p>All house staff will be retrained on when and how to complete the agency's Participant Internal Incident Report to ensure staff are reporting an unknown injury.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two months and then once a week ongoing. The QIDP will complete an observation of the group home</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818	
(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)
	<p>was not sure how client #2 had gotten the bump and red mark on his forehead. Staff #3 asked client #2 if he hit his head and client #2 did not answer. Staff #1 stated "We don't really know what he did. We will just have to take his word for it."</p> <p>Client #2's record was reviewed on 3/29/23 at 2:21 PM. Client #2's record did not indicate an Accident/Illness/Injury form had been filled out.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated she was not aware of an unknown injury for client #2. The DGH indicated staff should have filled out an Accident/Illness/Injury Form and reported it to the call center so an investigation could have been started.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated staff should have filled out an Accident/Illness/Injury form so an investigation into the unknown injury could have been started.</p> <p>2. Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:07 AM, staff #3 administered client #2 1 Multivitamin (for supplement) chewable tablet. Client #2 swallowed the tablet whole.</p> <p>Staff #3 was interviewed on 3/29/23 at 6:08 AM and stated client #2 "always" swallowed the chewable tablet and did not chew it.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated client #2 should chew his multivitamin.</p> <p>The agency's LPN was interviewed on 3/31/23 at 1:24 PM. The agency's LPN indicated client #2</p>			<p>once a week for two months and then twice a month ongoing. Both ensuring there are staff are reporting any unknown injuries. Persons Responsible: House Supervisor and QIDP Date Completed 5/5/2023 Client #2's Physician was notified that Client #2 is swallowing the chewable medication instead of chewing, and the physician did not believe this warranted a change in medication. Therefore, Addendum Form FSL-101 will be used to add to Client #2's program plan objectives to be prompted to chew the medication instead of swallow. The goal reads "[Client #2] will chew Multi vitamin chewable tablet with verbal prompt 5 of 7 days a week" to ensure the medication is being administered as prescribed. Person Responsible: QIDP Date Completed 5/5/2023 All house staff will be retrained on Quick Reference Guide for Medical Administration as well as complete Record of Supervised Medication Pass form FA-109 to ensure staff are trained and competent in administering medications. Persons Responsible: House Supervisor and QIDP Date Completed: 5/5/2023</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0227 Bldg. 00	<p>should be prompted to chew his multivitamin versus swallowing it.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated #2 should be prompted to chew his multivitamin.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review, and interview for 1 additional client (#5), the facility failed to develop a goal/plan to teach client #5 to not use her clothing to wipe her mouth.</p> <p>Findings include:</p> <p>Observations were completed in the home on 3/28/23 from 3:46 PM through 5:10 PM. At 4:18 PM, the QIDP (Qualified Intellectual Disability Professional) administered medications to client #5. Client #5 had applesauce on her face after taking her medications and wiped her mouth with the sleeve of her sweatshirt.</p> <p>Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:58 AM, client #5 was eating breakfast and wiped her mouth with the sleeve of her shirt. Staff #1 and #3 did not prompt client #5 to use a napkin to wipe her mouth.</p> <p>Client #5's record was reviewed on 3/29/23 at 1:00</p>		W 0227	<p>W227</p> <p>Addendum Form FSL-101 will be used to add to Client #5's program plan objectives to be prompted to wipe her mouth using a napkin. The goal reads "[Client #5] will wipe her mouth with a napkin instead of her clothing with gestural prompt 5 of 7 days a week" This goal will ensure the individual program plan states the specific objectives necessary to meet the client's needs.</p> <p>Person Responsible: QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two consecutive months and then once a week ongoing.</p> <p>Additionally, the QIDP will complete an observation of the group home once a week for two</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0240 Bldg. 00	<p>PM. Client #5's 11/3/22 Individual Support Plan (ISP) did not indicate client #5 had a goal to teach her to use a napkin to wipe her mouth.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH stated client #5 should have a goal to teach her to use a napkin "if she did it 2 times during observations" instead of her shirt sleeve.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated client #5 should have a goal to teach her to use a napkin instead of her shirt sleeve.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based record review and interview for 1 of 3 sampled clients (#1), the facility failed to define and have specific interventions for each behavior listed in client #1's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/29/23 at 9:37 AM. Client #1's 11/1/22 Behavior Support Plan (BSP) indicated client #1 had a behavior of Emotional/Behavioral Outbursts. The behavior of Emotional/Behavioral Outbursts was defined as "Any episode that includes, but is not limited to, two or more of the following behavioral examples: yelling, crying, physical aggression, property destruction, elopement, flopping to the floor, and/or verbal aggression. Ignoring is not an</p>		W 0240	<p>consecutive months and then twice a month ongoing. Both ensuring that Client 5's program plan objectives are being met, and meet the client's needs.</p> <p>Person Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>W240 Client #1's Behavior Support Plan will be updated to define and have specific interventions for each behavior listed. Each behavior listed within the defined behavior will have specific interventions for the staff to utilize. All Group Home staff that work with Client #1 will be trained on his updated Behavior Support Plan. Moving forward, Behavior Support Plans will be reviewed by the Director of Group Homes to ensure behaviors are defined and have specific interventions for each behavior listed.</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0247 Bldg. 00	<p>example of this target behavior ...".</p> <p>Each behavior listed within the defined behavior did not have specific interventions for staff to utilize.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated each behavior should have interventions for staff to utilize.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated each behavior should be defined and have interventions for staff to utilize.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(vi)</p> <p>INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3) plus 3 additional clients (#4, #5, and #6), the facility failed to ensure clients #1, #2, #3, #4, #5, and #6 had a choice in cereal, eggs, and fruit at breakfast.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:18 AM, staff #1 prepared scrambled eggs on the stove. Staff #1 did not ask clients #1, #2, #3, #4, #5, and #6 how they would like their eggs prepared. At 6:23 AM, staff #1 cut up bananas into bowls and placed them at clients #1, #3, #4, #5, and #6's place settings. Staff #1 placed a yogurt at client #2's place setting. Staff #1 did not</p>	W 0247	<p>Persons Responsible: QIDP, Director of Group Homes Date Completed: 5/5/2023</p> <p>W247</p> <p>All group home staff will be retrained on Active Treatment to ensure all clients have a choice the food they eat, and how it is prepared.</p> <p>Person Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two consecutive months, and then once a week ongoing.</p> <p>Additionally, the QIDP will complete an observation of the group home once a week for two</p>	05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0249 Bldg. 00	<p>ask client #2 if he wanted a banana or a yogurt for breakfast. At 6:25 AM, staff #1 poured cornflakes into bowls and placed them at clients #1, #2, #3, #4, #5, and #6's place settings. At 6:37 AM, clients #1, #2, #3, #4, #5, and #6 sat down at the kitchen table to eat breakfast. Staff #1 told client #2 "I gave you yogurt because I wasn't sure if you would want a banana." At 6:40 AM, staff #1 told client #5 "I didn't know if you wanted Reese Puffs or the cornflakes. You can't go wrong with the cornflakes."</p> <p>The undated group home menu was reviewed on 3/29/23 at 5:45 AM. The menu indicated breakfast was hot/cold cereal, egg of choice, and french toast.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated each client should have a choice in how their eggs are cooked, cereal, and fruit at breakfast.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated each client should have a choice in how their eggs are cooked, cereal, and fruit at breakfast.</p> <p>9-3-4(a)</p> <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</p>		<p>consecutive months, and then twice a month ongoing. Both ensuring all group home staff are providing opportunities to all clients for Active Treatment, and that all clients have a choice in the food they eat, and how it is prepared.</p> <p>Person Responsible: 5/5/2023 Date Completed: 5/5/2023</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>individual program plan.</p> <p>Based on observation, record review, and interview for 1 additional client (#5), the facility failed to ensure staff implemented goals during formal and informal opportunities.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:37 AM, client #5 came to the table to eat breakfast. Client #5 placed bites of cereal in her mouth until her mouth was full. At 6:46 AM, staff #3 prompted client #5 to slow down and take a drink of her juice. At 6:58 AM, client #5 put 3 bites of toast in her mouth. Staff #3 prompted client #5 to slow down and take a drink of juice. Client #5 stated "I don't want to, I'm eating." Staff #3 did not implement plate to plate (placing 1 bite of food on plate at a time) for client #5 during breakfast.</p> <p>Client #5's record was reviewed on 3/29/23 at 1:00 PM. Client #5's 10/31/22 Critical Risk Plan for Choking/Dining indicated "...Staff will serve [client #5's] meals on a plate-to-plate method ...".</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated client #5's food should be served using plate-to-plate method at all meals.</p> <p>The agency's LPN was interviewed on 3/31/23 at 1:24 PM. The agency's LPN indicated client #5's food should be served using plate-to-plate method at all meals.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated client #5's food should be served using plate-to-plate method at all meals.</p>	W 0249	<p>W249</p> <p>All group home staff will be retrained on the plate to plate method of dining to ensure staff follow Client #5's individual program plan receiving a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in the individual program plan.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two consecutive months, and then once a week ongoing.</p> <p>Additionally, the QIDP will complete an observation of the group home once a week for two consecutive months, and then twice a month ongoing. Both ensuring all staff are following Client #5's active treatment program, and that the plate to plate method is being implemented appropriately.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p>	05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0312 Bldg. 00	<p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's medication reduction plan objectives were attainable.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 3/30/23 at 2:21 PM. Client #2's 2/3/22 Behavior Support Plan (BSP) indicated he had behaviors of verbal aggression, physical aggression, resistive behaviors, and inappropriate social behaviors. Client #2's 2/3/22 BSP indicated client #2 took Paxil (for depression) 10 mg (milligrams). Client #2's Psychotropic Medication Reduction Plan indicated "...Plan for Medication Reduction: [Name of doctor] has indicated that Paxil would be considered for reduction provided [client #2] demonstrated reduce (sic) inappropriate social behaviors from 4 per year to 0 per year, reduce resistive behaviors from 2 per year to 0 per year, reduce physical aggression from 2 per year to 0 per year, reduce verbal aggression from 4 per year to 0 per year for 12 consecutive months. This criterion will continue until Paxil has been successfully discontinued. Should Paxil be successfully discontinued, or decreased to the most optimal dose for [client #2], criteria for reducing additional medications would not need to be considered because [client #2] does not take</p>		W 0312	<p>W312</p> <p>Client #2's Behavior Support Plan will be updated to ensure Client #2's medication reduction plan objectives are attainable. This medication reduction plan objective will be made attainable by identifying one goal to be successful in, instead of all of the goals. Moving forward, Behavior Support Plans will be reviewed by the Director of Group Homes to ensure that all other plans have medication reduction plan objectives that are attainable. All group home staff will be trained on the updated Behavior Support Plan.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0323 Bldg. 00	<p>any other psychotropic medications ...".</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated client #2's Psychotropic Medication Reduction Plan should have goals which were attainable. The DGH indicated client #2's goals are not attainable as written in his plan.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated client #2's Psychotropic Medication Reduction Plan should have goals which were attainable. The QIDP stated client #2's goals were "probably not" attainable.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's vision was examined every 2 years.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 3/20/23 at 2:21 PM. Client #2's record indicated his most recent vision examination was on 1/8/21. The facility was unable to provide a current vision exam for client #2 during the survey.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated each client's vision should be assessed every 2 years.</p>		W 0323	<p>W323 Client #2's vision appointment is scheduled for 5/11/2023. The Med Runner and QIDP's will meet monthly for three consecutive months, and then quarterly ongoing, to review appointments in order to ensure all clients are scheduled to have their necessary appointments on time, especially ensuring that vision appointments are occurring every 2 years. Persons Responsible: Med Runner DSP and QIDP Date Completed: 5/5/2023</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0331 Bldg. 00	<p>The agency's LPN was interviewed on 3/31/23 at 1:24 PM. The agency's LPN indicated each client's vision should be examined every 2 years.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated each client's vision should be assessed every 2 years.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#1), the facility's nursing staff failed to thoroughly complete a Fall Risk Assessment for client #1, develop a Fall Risk Plan for client #1, and ensure client #1 had neurological checks completed after he hit his head.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations, and incident reports were reviewed on 3/29/23 at 9:05 AM and indicated the following:</p> <p>1. A 12/7/22 Participant Internal Incident Report (PIIR) indicated "...Date/Time of incident: Dec 07, 2022 07:30 PM. Type of event/incident being reported: check all of the following that apply: Seizure Fall</p> <p>Staff response/action during and following internal incident: helped [client #1] roll on his back and had him stay laying down, staff called the call center and was advised to call 911 to take him to the hospital.</p>	W 0331	<p>W331</p> <p>Client 1's fall risk assessment will be completed thoroughly, and nursing will add a Fall Risk Plan to Client #1's individual support plan in order to ensure Client #1 is provided with nursing services in accordance with their needs. All group home staff will be trained on Client #1's fall risk plan.</p> <p>Persons Responsible: Nursing Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>Moving forward, Nursing and QIDP's will meet monthly in preparation for the Individual Support Plan's that are due the upcoming month, to complete the nursing assessments collaboratively, and then based on the assessment establish what risk plans will be added to the Individual Support Plan in the upcoming month.</p>	05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>Type of Injury: Bruising Describe Injury:: bruise forming on his forehead Injury Locator: Head = (equals) Front ...".</p> <p>A 12/8/22 BDDS report indicated "...On 12/7/2022, [client #1] had 3 seizures lasting less than a minute each in a two hour period, during the third seizure [client #1] fell and hit his head. At the time of the incident staff noted a bruise forming on his forehead. Staff called 911 and the EMS (Emergency Medical Services) transported [client #1] to the ER (Emergency Room) where he received BUN (Blood Urea Nitrogen)/ Creatinine ratio (measures amount of urea nitrogen in blood), Basic Metabolic Panel, CBC (Complete Blood Count) and Differential, estimated glomerular filtration rate (for kidney function), Liver profile, and magnesium labs ran. On 12/8/2022, [client #1] had a minute and 30 second seizure and fell onto his face in the process. Staff assessed [client #1] for injury and noted a cut above his left eye and a bump on his nose. Staff called 911 and [client #1] was transported via EMS to [name of hospital], [client #1] was admitted and is being monitored and treated for his seizures and the injuries he sustained from the seizure. ESAr (Easter Seals ARC) will be in close communication with [name of hospital] regarding diagnosis, testing, treatments, and anticipated discharge date. Once discharged ESAr will follow all physician orders ...ESARC will continue to provide for [client #1's] health, safety, and wellbeing."</p> <p>Client #1's record was reviewed on 3/29/23 at 9:37 AM. Client #1's record did not indicate a Post Head Injury Follow Up was completed for his falls on 12/7/22 and 12/8/22.</p> <p>2. A 12/6/22 PIIR indicated "...Staff didn't see the fall, but as soon as she noticed him (client #1) on</p>	<p>Persons Responsible: Nursing Supervisor and QIDP Date Completed: 5/5/2023 All group home staff will be retrained on when and how to complete neurological checks. To ensure that neurological checks are being completed in their entirety, the QIDP will set a calendar invite with a deadline of when the neurological checks need to be turned in. The QIDP will follow up with the House Supervisor if the neurological checks are not submitted completed within 24 hours of the deadline.</p> <p>Persons Responsible: House Supervisor and QIDP Date Completed: 5/5/2023</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>the floor she went to him and asked him how he fell. She looked him over and asked him if he bumped his head. She felt the back of his head and didn't feel a bump. Type of Injury: No Apparent Injury ...".</p> <p>Client #1's record did not indicate a Post Head Injury Follow Up was completed for his unwitnessed fall on 12/6/22.</p> <p>3. An 8/4/22 PIIR indicated "...Date/Time of incident: Aug 04, 2022 06:30 AM. Type of event/incident being reported: check all of the following that apply: Fall. Staff response/action during and following internal incident: Staff was using the restroom and heard a loud thud and went and checked on clients (sic) and saw him (client #1) on the floor. He got right up and was walking around. Type of Injury: No Apparent Injury ...".</p> <p>Client #1's record did not indicate a Post Head Injury Follow Up was completed for his unwitnessed fall on 8/4/22.</p> <p>4. A 7/26/22 PIIR indicated "...Staff heard something loud and went to go check it out and saw him (client #1) on the floor. Type of Injury: No Apparent Injury ...".</p> <p>Client #1's record did not indicate a Post Head Injury Follow Up was completed for his unwitnessed fall on 7/26/22.</p> <p>Client #1's record was reviewed on 3/29/23 at 9:37 AM. Client #1's 3/10/23 Risk Plans did not indicate he had a risk plan created for falls.</p> <p>Client #1's record indicated client #1 had a Fall Risk Assessment (FRA) completed on 4/25/22.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>Client #1's FRA was not completed in its entirety. Client #1's score from the FRA was a 10. The FRA indicated "...A score of 10 or more indicates high risk for falls. Plan is needed to address/minimize identified risks ...". The facility failed to fill out the FRA in its entirety and give an accurate score. Client #1's score of 10 indicated a Fall Risk Plan should have been created for client #1.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated client #1's FRA should have been completed in its entirety. The DGH indicated since client #1 had a score of 10 he should have had a Fall Risk Plan. The DGH indicated client #1 should have had a Post Injury Follow Up completed for any fall where he hit his head or it was an unwitnessed fall.</p> <p>The agency's LPN was interviewed on 3/31/23 at 1:24 PM. The agency LPN indicated client #1's FRA should have been completed in its entirety. The agency LPN indicated since client #1 had a score of 10 he should have had a Fall Risk Plan. The agency LPN indicated client #1 should have had a Post Injury Follow Up completed for any fall where he hit his head or it was an unwitnessed fall. The agency LPN indicated the only time client #1 would not have a Post Head Injury Follow up form completed was if he went to the Emergency Room and had an MRI (Magnetic Resonance Image) or CT (Computed Tomography) scan. The agency LPN indicated the Post Head Injury Follow Up form would ensure staff tracked symptoms such as: nausea/vomiting, confusion/memory loss, blurred vision, increased/decreased sleep, severe headache, and lack of coordination.</p> <p>The Qualified Intellectual Disability Professional</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA		STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0475 Bldg. 00	<p>(QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated client #1's FRA should have been completed in its entirety. The QIDP indicated since client #1 had a score of 10 he should have had a Fall Risk Plan. The QIDP indicated client #1 should have had a Post Injury Follow Up completed for any fall where he hit his head or it was an unwitnessed fall.</p> <p>9-3-6(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES</p> <p>Food must be served with appropriate utensils. Based on observation and interview for 3 of 3 sampled clients and 3 additional clients, the facility failed to ensure clients had a full set of utensils and more than 1 cup at meals.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:40 AM, clients #1, #2, #3, #4, #5, and #6 came to the kitchen table to eat breakfast. The breakfast served was cereal, toast, bananas, sausage links, juice, milk, and water. Each client was given 1 cup, spoon and a fork. Client #1 had to use a fork to spread jelly on his toast. Staff #1 cut each clients' sausage and bananas up for them before bringing them to the table.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated each client should have a full set of utensils and 2 cups for each meal.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM.</p>	W 0475	<p>W475</p> <p>All group home staff will be retrained on appropriate table setting, in particular, providing a full set of utensils and more than 1 cup at meals.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two consecutive months, then weekly ongoing. The QIDP will complete an observation of the group home once a week, then twice a month ongoing. Both ensuring that the group home staff provide opportunities for family style dining,</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p>	05/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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 0488 Bldg. 00	<p>The QIDP indicated each client should have a full set of utensils and 2 cups for each meal.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3) plus 3 additional clients (#4, #5, and #6), the facility failed to ensure clients had the opportunity to help prepare meals, set the table, and participate in family style dining.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 3/29/23 from 5:38 AM through 7:30 AM. At 6:18 AM, staff #1 went in the kitchen, placed bread on a baking sheet, and added butter to the bread. Staff #1 put the bread in the oven. At 6:20 AM, staff #1 got out eggs from the refrigerator and a mixing bowl from the cabinet. Staff #1 cracked eggs into the mixing bowl and mixed them. At 6:22 AM, staff #1 poured the eggs in a skillet and cooked them on the stove. Staff #1 did not ask clients #1, #2, #3, #4, #5, and #6 to help prepare the eggs and toast. At 6:23 AM, staff #1 cut up bananas and put them in 4 separate bowls. Staff #1 poured cornflake cereal in 5 separate bowls. Staff #1 took the bananas and the cereal to the table and placed them at each clients' place setting. Staff #1 went back to the stove and stirred the eggs. At 6:32 AM, staff #1 placed scrambled eggs and toast on each clients' plate and took them to each of their place settings at the table. Clients #1, #2, #3, #4, #5, and #6 were not prompted to help set the table or given the</p>		W 0488	<p>W488</p> <p>All group home staff will be retrained on family style dining, and providing opportunities for clients to help to prepare meals, and set the table.</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p> <p>The House Supervisor will complete an observation of the group home twice a week for two consecutive months, then weekly ongoing. The QIDP will complete an observation of the group home once a week, then twice a month ongoing. Both ensuring that the group home staff provide opportunities for family style dining,</p> <p>Persons Responsible: House Supervisor and QIDP</p> <p>Date Completed: 5/5/2023</p>	05/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G752	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2023	
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818		
(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
	<p>opportunity to participate in family style dining.</p> <p>The Director of Group Home (DGH) was interviewed on 3/31/23 at 1:00 PM. The DGH indicated the clients should have been prompted to help make breakfast, set the table, and have the opportunity to participate in family style dining.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 3/31/23 at 1:41 PM. The QIDP indicated clients should help prepare meals and set the table. The QIDP indicated clients should be able to have the opportunity to participate in family style dining.</p> <p>9-3-8(a)</p>				