

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

PRINTED: 05/30/2023  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15G752		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 04/27/2023	
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 9104 STRATHMORE LN FORT WAYNE, IN 46818			
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 04/27/23</p> <p>Facility Number: 011871 Provider Number: 15G752 AIM Number: 200921870</p> <p>At this Emergency Preparedness survey, Easter Seals Arc of Northeast Indiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6</p> <p>Quality Review completed on 05/04/23</p>			E 0000			
E 0037  Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54,</p>						

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

TITLE

(X6) DATE

Katlyn Rife

Director of Group Homes

05/19/2023

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 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 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>Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency</p>						

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	<p>preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p>						

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	<p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p>						

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p>						

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K 0000  Bldg. 01	<p>Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Maintenance Supervisor on 04/17/23 at 11:40 a.m., there was no documentation available for review to indicate all staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the Maintenance Supervisor did not know if staff were trained on the EPP, and stated no documentation for staff training could not be found during the survey.</p> <p>This finding was reviewed with the Maintenance Supervisor during the exit conference.</p> <p>A Life Safety Code (LSC) Recertification Survey</p>			E 0037	<p><b>A competency based test was created in order to track staff's demonstration of knowledge on Emergency Preparedness Program.</b></p> <p><b>All staff will be retrained on Easter Seals Disaster Preparedness Policy, and all staff will complete the competency based test on the information. Ongoing, staff will complete the competency based test annually.</b></p> <p><b>Person Responsible: House Supervisor/QIDP</b></p> <p><b>Date of Completion: 5/19/2023</b></p>		05/19/2023

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K S363  Bldg. 01	<p>was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 04/27/23</p> <p>Facility Number: 011871 Provider Number: 15G752 AIM Number: 200921870</p> <p>At this LCS survey, Easter Seals Arc of Northeast Indiana was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a fire alarm system with heat detection in the attic, smoke detection in the corridors, sleeping rooms and common living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches of Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.24.</p> <p>Quality Review completed on 05/04/23</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed.</p>						

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	<p>2. No doors shall be arranged to prevent the occupant from closing the door.</p> <p>3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7</p> <p>Based on observation and interview, the facility failed to ensure the doors to 2 of 5 clients sleeping rooms were not obstructed from closing. This deficient practice could affect 2 client.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 04/27/23 at 12:08 p.m., sleeping room doors #2 and #3 were obstructed from closing due to the doors being propped open with a door wedge. Based on interview at the time of observation, the Maintenance Supervisor confirmed the doors were obstructed from closing due to a door wedge.</p> <p>This finding was reviewed with the Maintenance Supervisor during the exit conference.</p>	K S363	<p><b>All staff will be been retrained on Disaster Preparedness Policy, especially fire procedures.</b></p> <p>/b&gt;</p> <p>/b&gt;</p> <p>/b&gt;</p> <p>/b&gt;</p> <p><b>The house supervisor will complete an observation of the home three times per week for two months and once a week ongoing. The QIDP will complete an observation of the home once per week for two months and then twice a month ongoing. Both ensuring nothing is propping any doors open and that all door leaves normally required to be kept closed shall not be secured in the open position at any time</b></p> <p>Person Responsible: House supervisor/QIDP</p>		05/19/2023		



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