

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2021
NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST		STREET ADDRESS, CITY, STATE, ZIP COD 5924 ABBOTT ST FORT WAYNE, IN 46816		
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W 0000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey.</p> <p>Survey Dates: 1/21, 1/22, 1/26, and 1/29/21.</p> <p>Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 2/10/21.</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 observation, record review, and interview for 1 of 3 sampled clients (#2), the governing body failed to ensure the agency's policy and procedure for the care and maintenance of liquid oxygen and portable oxygen tanks at the facility included hazard warning labels on client #2's bedroom window regarding oxygen in use and proper storage for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 1/21/21 from 3:00 PM through 5:07 PM and 1/22/21 from 5:50 AM through 8:00 AM. Throughout both observation periods client #2's</p>	W 0104	<p><u>W104</u></p> <p>A hazard warning label was placed on client #2's outside bedroom window due to the presence of liquid oxygen in the room.</p> <p>Person Responsible: House Manager</p> <p>Completion Date: 01/29/2021</p> <p>All empty oxygen tanks been removed from client #2's bedroom. Additionally, all other free-standing tanks have been secured in an upright position in a stand or a cart.</p> <p>Person Responsible: House Manager</p>	02/28/2021

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 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.

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	<p>room had multiple oxygen tanks and an oxygen concentrator in her room. There was not an oxygen sign present on client #2's outside bedroom window. A canister was sitting on client #2's dresser and not secure in a cart.</p> <p>The House Manager (HM) was interviewed on 1/21/21 at 4:00 PM and indicated client #2 utilized oxygen while she slept at night.</p> <p>The HM was interviewed on 1/22/21 at 7:21 AM and indicated there was not a sign on the outside window of client #2's room and there should be in case of a fire. The HM indicated client #2 had an oxygen tank on her dresser and it should be stored in a cart to prevent it from tipping over.</p> <p>Client #2's record was reviewed on 1/22/21 at 11:49 AM. Client #2's 11/17/20 Quarterly Nursing Assessment indicated client #2 was on 1 L (liter) of oxygen.</p> <p>The Director of Nursing (DON) was interviewed on 1/26/21 at 11:50 AM. The DON indicated client #2 was currently on oxygen at night. The DON indicated oxygen tanks should be stored upright in a container to prevent them from tipping over. The DON indicated a sign should be placed on the outside window of client #2's bedroom.</p> <p>The Director of Group Homes (DGH) was interviewed on 1/26/21 at 12:26 PM. The DGH indicated a sign should be placed on the outside bedroom window and the oxygen should be stored upright in a cart to ensure it does not tip over. The DGH indicated she thought the oxygen tank was empty but would check with the HM and get any oxygen tanks out of the home which were not needed.</p>		<p>Completion Date: 01/29/2021 All Group Home Staff including House Manager will be retrained over the facility's 12/27/19 Oxygen Use at Home SOP.</p> <p>Person Responsible: QIDP Completion Date: 02/28/2021 The House Manager will complete daily checks while on shift of client # 2's bedroom for 1 month and then 3 times weekly ongoing ensuring all hazard warning labels are in place as well as ensuring all free-standing tanks are being secured in an upright position in a stand or a cart. In addition the QIDP will also complete an observation of client # 2's bedroom weekly for 4 weeks and once a month on an ongoing basis to ensure all hazard warning labels are in place as well as ensuring all free-standing tanks are being secured in an upright position in a stand or a cart. The observations will be documented, and any issues noted will be corrected.</p> <p>Person Responsible: House Manager/QIDP Completion Date: 02/28/2021</p>	

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W 0227  Bldg. 00	<p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 1/26/21 at 6:11 PM. The QIDP indicated there should be an oxygen sign on the outside bedroom window and the oxygen tanks should be stored upright in a cart to prevent them from tipping over.</p> <p>The facility's 12/27/19 Oxygen Use at Home SOP (Standard Operating Procedure) was reviewed on 1/29/21 at 10:00 AM and indicated "...Put signs on all doors to let visitors and emergency personnel know oxygen is in use. 'No Smoking' signs should also be posted ... Oxygen tanks should always be stored in a stand or cart to prevent tipping or falling. Unsecured tanks should be placed flat on the floor. Do not allow tanks to stand or lean in an upright position while unsecured...".</p> <p>9-3-1(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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. Based on observation, record review, and interview for 1 of 3 sampled clients (#3), the facility failed to create a goal/plan to encourage client #3 to exercise.</p> <p>Findings include:  Observations were completed in the group home on 1/21/21 from 3:00 PM through 5:07 PM. Throughout the majority of this observation period client #3 laid on the couch and played on his tablet. Client #3 was not encouraged or</p>	W 0227	<p><u>W227</u></p> <p>ISP's for all clients will be reviewed to ensure that they contain objectives necessary to meet the client's needs. An addendum will be added to client #3's plan including an objective to exercise. Staff will be trained on implementation of the new objective. The QIDP will complete</p>	02/28/2021

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	<p>prompted by staff to get up and move around.</p> <p>Client #3's record was reviewed on 1/22/21 at 10:20 AM. Client #3's 10/28/20 Individual Support Plan (ISP) did not indicate client #3 had a goal to exercise.</p> <p>Client #3's 1/29/20 Annual Nutritional Assessment indicated the dietician recommended the facility discontinue double portions and Ensure (nutritional supplement) daily.</p> <p>Client #3's 5/22/19 Quarterly Nursing Assessment (QNA) indicated client #3's weight was 209 lbs. (Pounds). Client #3's 8/30/19 QNA indicated client #3 weighed 222 lbs. Client #3's 2/25/20 QNA indicated client #3 weighed 225 lbs. Client #3's 5/21/20 QNA indicated client #3 weighed 225 lbs. Client #3's 8/24/20 QNA indicated client #3 weighed 231 lbs. Client #3's 12/5/20 QNA indicated client #3 weighed 241 lbs.</p> <p>Client #3's record indicated on 10/23/20 his psychiatrist discontinued his Paxil (sexual anxiety) 10 mg (milligrams).</p> <p>The Director of Nursing (DON) was interviewed on 1/26/21 at 11:50 AM. The DON indicated client #3 had gained weight over the past year. The DON stated the facility "felt" he had gained the weight from his Paxil, but it had been discontinued in October of 2020 and she was not sure if results would be showing yet. The DON indicated client #3 could benefit with a goal to increase his exercise.</p> <p>The Director of Group Homes (DGH) was interviewed on 1/26/21 at 12:26 PM. The DGH indicated client #3 had gained weight over the past year. The DGH stated she "thought" it was</p>		<p>an observation of the home weekly for 4 weeks and then monthly on an ongoing basis to monitor for active treatment issues and to determine if the clients' plans should be updated. The observations will be documented, and any issues noted will be corrected.</p> <p>Person Responsible: QIDP Date Completed: 02/28/2021</p>	

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W 0382  Bldg. 00	<p>because of his Paxil which had been decreased in October of 2020. The DGH indicated client #3 can be difficult to get up and get active and will refuse a lot of the time. The DGH stated she "had hoped the discontinuation of Paxil would result in him losing the weight he gained while on it." The DGH indicated client #3 could benefit from an exercise goal.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 1/26/21 at 6:11 PM. The QIDP indicated client #3 had gained a significant amount of weight over the past year. The QIDP stated she "had not considered an exercise goal in the past." The QIDP indicated she was waiting to see the results from his discontinuation of Paxil but it had not happened yet. The QIDP indicated he could benefit from an exercise goal.</p> <p>9-3-4(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 1 of 3 sampled clients (#2), the facility failed to ensure medications were locked when not being administered.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 1/21/21 from 3:00 PM through 5:07 PM. At 3:40 PM, the HM (House Manager) had client #2 come to the medication room to take her medications. The HM took out client #2's bin of medications and placed it on the desk. The HM asked client #2</p>	W 0382	<p><u>W382</u> All group home staff including the house manager will be retrained on securing medications. Person Responsible: House Manager/QIDP Completion date: 02/28/2021</p> <p>The House Manager will complete an observation of the group home twice weekly while on shift for one month and then weekly ongoing checking to ensure all</p>	02/28/2021

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W 0475  Bldg. 00	<p>if she wanted to take her medication in applesauce. Client #2 indicated she did want applesauce. The HM left the medication room with the medications out on the desk while client #2 waited in the room. The HM went to the kitchen and came back and administered client #2's medications to her.</p> <p>The HM was interviewed on 1/21/21 at 3:50 PM. The HM indicated he did leave the medications out when he went to go get the applesauce in the kitchen. The HM stated he should not have left them out and he was "thrown off" by client #2 requesting applesauce because "normally she just takes her medications with water."</p> <p>The Director of Nursing (DON) was interviewed on 1/26/21 at 11:50 AM. The DON indicated the HM should have locked the medications back up when he went to go get the applesauce.</p> <p>The Director of Group Homes (DGH) was interviewed on 1/26/21 at 12:26 PM. The DGH indicated medications should not be left out when not being administered.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 1/26/21 at 6:11 PM. The QIDP indicated medications should not be left out when not being administered.</p> <p>9-3-6(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3) plus 5 additional clients (#4, #5, #6, #7, and #8), the facility failed to</p>	W 0475	<p>medications are secured appropriately. In addition, the QIDP will complete an observation of the group home once weekly for 4 weeks and then once a month ongoing checking to ensure that medications are secured appropriately. The observations will be documented, and any issues noted will be corrected.</p> <p>Person Responsible: QIDP/House Manager</p> <p>Completion date: 02/28/2021</p>	02/28/2021

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W 0488  Bldg. 00	<p>ensure clients were given a full set of utensils at breakfast.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 1/22/21 from 5:50 AM through 8:00 AM. The meal consisted of fried potatoes, sausage links, biscuits, and scrambled eggs with cheese. At 6:30 AM, staff #3 started to place cups and plates on the table at each client's place setting. Staff #3 placed a fork at each client's setting. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were not given a spoon or knife.</p> <p>The Director of Group Homes (DGH) was interviewed on 1/26/21 at 12:26 PM. The DGH indicated each client should have been given a full set of utensils.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 1/26/21 at 6:11 PM. The QIDP indicated each client should have been given a full set of utensils.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>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, #3) plus 5 additional clients (#4, #5, #6, #7, and #8), the facility failed to encourage clients #1, #2, #3, #4, #5, #6, #7, and #8 to help prepare their breakfast and set the table, and encourage clients #3 and #8 to participate in family style dining.</p>	W 0488	<p>on providing the appropriate utensils at each meal. In addition the group home manager will complete an observation of the group home twice a week for one month and once weekly ongoing during meal times and the QIDP will complete an observation of the group home during meal times once weekly for 4 weeks and then once a month ongoing to ensure that clients are provided with the appropriate utensils during meals. The observations will be documented, and any issues noted will be corrected.</p> <p>Person Responsible: QIDP/Home Manager</p> <p>Date Completed: 02/28/2021</p> <p><u>W488</u></p> <p>Group Home staff will be retrained on teaching and encouraging family style dining and active treatment during each meal. In addition, the group home manager will complete an observation of the group home twice weekly for one</p>	02/28/2021

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	<p>Findings include:</p> <p>Observations were completed in the group home on 1/21/21 from 3:00 PM through 5:07 PM. At 4:50 PM, clients #3 and #8 came to their place setting at the kitchen table. Clients #3 and #8's food was already on their plates when they came to sit down.</p> <p>Observations were completed in the group home on 1/22/21 from 5:50 AM through 8:00 AM. At 6:25 AM, staff #3 went into the kitchen and started to cut up potatoes and onions. Staff #3 indicated she was making fried potatoes, sausage, biscuits, and scrambled eggs with cheese for the clients in the home. Staff #3 continued to make breakfast and did not prompt or ask clients #1, #2, #3, #4, #5, #6, #7, or #8 to help make the breakfast. At 6:30 AM, staff #3 started to place cups and plates on the table at each client's place setting. At 6:45 AM, staff #3 was in front of the stove cooking the eggs and potatoes. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were in their rooms and not prompted to help cook. At 7:05 AM, staff #3 asked client #6 to take drinks and food to the kitchen table. At 7:20 AM, staff #3 prompted all of the clients to come out of their rooms and wash their hands for breakfast.</p> <p>The Director of Group Homes (DGH) was interviewed on 1/26/21 at 12:26 PM. The DGH indicated staff should be prompting clients in the group home to help set the table and help prepare their meals. The DGH indicated staff should help clients #3 and #8 serve themselves in a family style setting.</p> <p>The Qualified Intellectual Disability Professional (QIDP) was interviewed on 1/26/21 at 6:11 PM. The QIDP indicated staff should encourage</p>	<p>month during mealtimes and once weekly ongoing. In addition the QIDP will complete an observation of the group home once weekly for 4 weeks and once monthly on an ongoing basis to ensure that staff is encouraging and teaching clients during meal preparation tasks. The observations will be documented and any issues noted will be corrected.</p> <p>Person Responsible: QIDP/Home Manager</p> <p>Date Completed: 02/28/2021</p>		

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	clients to help make their breakfast and set the table in the morning. The QIDP indicated staff could help clients #3 and #8 serve themselves by using hand over hand.  9-3-8(a)			