

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2022
NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST		STREET ADDRESS, CITY, STATE, ZIP COD 4420 WOODSTOCK FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a focused fundamental recertification and state licensure survey.</p> <p>Survey Dates: 5/4, 5/5, and 5/6/2022.</p> <p>Facility Number: 000618 Provider Number: 15G074 AIM Number: 100233730</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by 27547 on 5/31/22.</p>	W 0000		
W 0368 Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients (#2), the facility failed to administer medications according to physician's orders.</p> <p>Findings include:</p> <p>An observation was completed in the group home on 5/4/22 from 5:42 AM through 7:35 AM. At 6:20 AM, staff #4 administered 1 tablet Levothyroxine (for thyroid) 100 mcg (micrograms) to client #2. At 6:21 AM, client #2 went to the kitchen table and started eating breakfast.</p> <p>Client #2's record was reviewed on 5/5/22 at 11:20</p>	W 0368	<p>W 368 All house staff will be retrained on proper medication administration which includes ensuring all medications are passed according to physician's orders. Person Responsible: QIDP/House Supervisor Date Completed: 06/12/22 The house supervisor will complete a supervised med pass with all house staff once a month for two months and then ongoing yearly checking to ensure that the medications are administered according to physician's orders.</p>	06/12/2022

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.

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

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	<p>AM. Client #2's 4/5/22 Physician's Orders indicated client #2 took 1 tablet Levothyroxine 100 mcg every morning on an empty stomach.</p> <p>The agency RN (Registered Nurse) was interviewed on 5/6/22 at 11:24 AM. The agency RN indicated client #2 should wait at least 30 minutes after taking his Levothyroxine to eat or take his other medications.</p> <p>9-3-6(a)</p>		<p>Person Responsible: House Supervisor</p> <p>Date Completed: 06/12/22</p> <p>The house supervisor will complete and observation of the home two times per week for two months and weekly ongoing. Additionally, the QIDP will complete an observation of the home two times monthly and on an ongoing basis both monitoring to ensure medications are being administered according to physician's orders. The observations will be documented, and any issues noted will be corrected.</p> <p>Person Responsible: QIDP/House Supervisor</p> <p>Date Completed: 06/12/22</p>	