

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/24/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC-ARC AVE (105)			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591		
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W0000	<p>This visit was for a post-certification revisit (PCR) survey to the investigation of complaint #IN00104180 completed on 3/12/12.</p> <p>This visit was in conjunction with a pre-determined full recertification and state licensure survey.</p> <p>Complaint #IN00104180-Not Corrected.</p> <p>Dates of Survey: 4/17, 4/18, 4/19, 4/20 and 4/24/12</p> <p>Facility Number: 002937 Provider Number: 15G693 Aim Number: 200333060</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/1/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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 that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to falls.</p> <p>Findings include:</p> <p>During the 4/17/12 observation period between 3:45 PM and 6:50 PM, at the group home, client A wore a helmet and staff physically assisted the client when ambulating. Staff #1, #2, #3 and/or #4 physically assisted client A to walk by holding his arm at his elbow, intertwining staff's arm with client A's arm, and/or intertwining staff's arm with client A's arm while holding his hand. Staff walked next to client A when he stood and attempted to ambulate. Client A had an unsteady gait as he walked.</p> <p>During the 4/18/12 observation period between 5:35 AM and 8:10 AM, at the group home, at 6:15 AM, client A removed his helmet to take his morning medications. Client A had about a 2 inch red abraded area about 1/4 inch wide above his left eye with 2 small pinpoint scabs below the abraded area. Interview</p>	W0149	<p>Plan of Correction: Staff will be retrained on the abuse neglect policy. The Manager and nursing staff will be retrained on when it is appropriate to call an IDT meeting. An IDT meeting will be held regarding Client A's falls. Client A's risk plan will be revised to include the specifics of how to ambulate with Client A. All staff will be retrained on Client A's risk plan. Nursing staff will be retrained on including the specifics of ambulation techniques in risk plans</p> <p>Preventive Action: All staff will be retrained on the abuse/neglect policy. The Manager and nursing staff will be retrained on when it is appropriate to call an IDT meeting. Nursing staff will be retrained on including the specifics of ambulation techniques in risk plans.</p> <p>Monitoring: The Director of Health Services will monitor the completion of the revisions to Client A's risk plan. The Director of Health Services will monitor the completion of the training of nursing staff. The Director of Residential Services will monitor the completion of the training of Direct Support Professionals, the Assistant Manager and the</p>	05/24/2012			

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	<p>with client A on 4/18/12 at 6:15 AM indicated he (client A) fell while at a Special Olympics outing.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 4/18/12 at 11:14 AM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-3/24/12 "On 3/24/12, approximately 5:30 PM, [client A] was walking with staff assistance. His feet became tangled and staff lowered him to the floor between staff and a door frame. While lowering him, he hit a door knob and hinge resulting in three injuries. He had an abrasion on his right shoulder 1 1/2 inches by 5/8 inches wide. He had a 12 inch welt on his right side by the rib cage. He had a 4 inch welt by his right arm pit...The staff is to continue to follow his high risk plans for falls and report any issues to the nurse."</p> <p>-3/14/12 "The consumer was walking and tripped over another consumer's wheelchair, causing him to fall...." The reportable incident report indicated client A had a "...small scrape to the right side of the consumer's face...."</p> <p>-2/8/12 "It was reported that while staff was assisting [client A] transferring from</p>		<p>Manager. The Director of Residential Services will monitor the completion of the IDT meeting.</p> <p>Date to Be Completed By: May 24, 2012 Responsible Party: Director of Health Services, Director of Residential Services</p>				

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	<p>his recliner to his wheelchair. (sic) [client A] fell forward,...." The reportable incident report indicated client A had 2 bruises to his right thigh.</p> <p>The facility's 3/5/12 follow-up report indicated "The staff prompts [client A] when he is getting ready to stand to slow down so that he will not lose his balance when he stands up. Staff will continue to follow his high risk plan and report any issues to the nurse."</p> <p>-1/9/12 "It was reported [client A] was walking down the hallway with staff and lost his balance. Staff tried to catch him but on the way down [client A] caught a wheelchair along the wall. The nurse assessed [client A] and found a small bump on the left side of his forehead." The reportable incident report indicated a wheelchair had been ordered for transportation.</p> <p>-12/29/11 "On 10/29/11 (sic),...[Client A] went in the restroom and fell next to the toilet. He bit his tongue but had no other injuries."</p> <p>The facility's 1/10/12 Investigation Summary indicated a wheelchair had been ordered for outside transportation for more than 50 feet and was to be used if the client had "...unsteady gait, weakness,</p>			
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	<p>or problems arising from a sitting position. An appointment has been made with his PCP (primary care physician). This was requested by the guardian with the purpose of checking his ankles to see if [client A] is in need of braces to help steady his balance. The PCP will decide if [client A] needs braces."</p> <p>-12/23/11 "It was reported while [client A] was on his way to bed with staff, [client A] tripped and fell over his own feet. Staff was able to catch [client A] as he fell..." The reportable incident report indicated client A received a "rug burn" on his right elbow.</p> <p>-12/8/11 "While on the way restroom, [client A] lost his balance and fell (sic)...." The reportable incident report indicated client A was sent out to a local hospital to have the client's knee checked.</p> <p>-11/26/11 Client A fell while he was at the Baler Center (facility owned day program). The reportable incident report indicated "...a small laceration was found above his right eyebrow. The laceration was received during the fall from his glasses...."</p> <p>-11/14/11 Client A fell walking down the sidewalk "hurriedly...and stumbled onto the concrete. He busted his nose and</p>						

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	<p>sustained a gash above his right eye. He also broke his glasses." The reportable incident report indicated client A was sent to the emergency room (ER) to be assessed.</p> <p>-11/2/11 "While [client A] was getting dressed, he tripped over the door frame. The staff tried to catch him but he fell into his dress (sic). He has a goose egg in the center of his head and a scratch above his right eye brow...." The reportable incident report indicated client A was "counseled" about walking slowly and paying more attention to the objects around him.</p> <p>-8/1/11 Client A fell on his buttock after returning from an outing. The reportable incident report indicated client A was not injured.</p> <p>The facility's 4/11 to 4/12 reportable incident reports did not indicate the facility reported client A's fall at the Special Olympics event which resulted in an injury to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Client A's record was reviewed on 4/19/12 at 11:07 AM. Client A's record indicated his past Physical Therapy (PT) evaluation was completed on 4/8/10. Client A's 4/8/10 PT evaluation indicated</p>				

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	<p>"...Gait: Pt is ambulating (with) (I) (independence) (with) slight limp on (R) (right) LE (lower extremity)...." The 4/8/10 PT evaluation indicated client A was to perform daily range of motion and stretching exercises for his right hand, wrist, arm and ankle. The 4/8/10 PT evaluation did not indicate client A's ambulation/gait had been re-assessed due to the client's falls and/or required physical assistance with ambulation.</p> <p>Client A's 3/23/12 nurse note indicated "Request for OT/PT sent and approved."</p> <p>Client A's 1/6/12 faxed note indicated "...Wheelchair PRN (as needed) for outside transportation of more than 50 feet and also per staff direction due to unsteady gait, weakness, or problems arising from seated position."</p> <p>Client A's 7/15/11 Individual Program Plan (IPP) indicated client A's diagnosis included, but was not limited to, Right Sided Hemiparesis. Client A's IPP indicated the client had a risk plan for falls which indicated the client was "High Risk for Falls due to Awkward Gait and Hemiparesis...." Client A's risk plan indicated "1. Continue use of helmet as ordered by physician. 2. Obtain PT/OT (occupational therapy) evaluation as ordered by physician. 3. Use wheelchair</p>						

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	<p>for unsteadiness as ordered by physician.</p> <p>4. Ambulate with consumer for short distances. 5. Do not use area rugs and keep pathways clear. 6. Contact nurse with any falls and complete a (sic) accident/incident form. 7. Nurse will assess falls for injury and contact physician if injury occurs...Review & (and) Analysis...2. Nurse will monitor falls monthly for trends/patterns. 3. Nurse will monitor PT/OT evaluations to ensure recommendations are completed as ordered....." Client A's record and/or 7/15/11 IPP did not indicate how facility staff should assist/ambulate with client A to prevent the client from falling. Client A's record and/or IPP also did not indicate client A's IDT (interdisciplinary team) met to review and/or discuss client A's falls and/or increased problems with the client's gait/ambulation.</p> <p>Interview with staff #4 on 4/18/12 at 7:45 AM indicated client A received the injury above his left eye from a fall while at a Special Olympics event. Staff #4 stated "Staff walked with him (client A) because he is unsteady."</p> <p>Interview with client A's guardian on 4/20/12 at 8:56 AM indicated client A had been falling when he ambulated. Client A's guardian stated client A "fell a few days ago and received the injury to</p>						

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	<p>his head." Client A's guardian indicated it was on Saturday 4/14/12. Client A's guardian indicated facility staff were to supervise the client when walking/ambulating. Client A's guardian stated "I don't want him wheelchair bound."</p> <p>Interview with administrative staff #1, #2 and #3 on 4/20/12 at 11:00 AM indicated client A fell at the Special Olympics and hurt his area above his eye. Administrative staff #3 indicated she thought the 4/14/12 incident had been reported, but later indicated it had not been reported until 4/20/12. Administrative staff #1, #2 and #3 indicated facility staff were to walk with client A and assist the client to ambulate. When asked how facility staff were to walk with/ambulate with the client, administrative staff #1 indicated client A's IPP did not clearly indicate how facility staff were to ambulate with the client. Administrative staff #1 and #3 indicated client A was scheduled for a PT evaluation on 4/27/12. Administrative staff #1 and #3 indicated client A had not been assessed for the need/use of gait belt when ambulating.</p> <p>Interview with administrative staff #1 on 4/20/12 at 12:52 PM indicated client A's IDT had met in regard to the client's falls.</p>						

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	<p>Administrative staff #1 stated "No IDT. Spoke with Dad and documented conversation as IDT is to be scheduled."</p> <p>The facility's policy and procedures were reviewed on 4/19/12 at 1:12 PM. The facility's 12/1/11 policy entitled Neglect, Abuse, Battery, Exploitation Policy And Incident Reporting/Investigatory Procedure indicated "Neglect means failure to provide goods and services necessary to avoid physical or psychological harm. It is a situation that creates danger to an individual's physical or mental health because the caregiver is unable or fails to provide necessary support such as food, shelter, clothing, medical care, protection/safety, social-emotional needs, and developmental needs."</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>This deficiency was cited on 3/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (C) and for 1 additional client (H), the facility's nursing services failed to monitor client H in regard to a healed sore on the client's foot and to follow up an abnormal lab result with client C's physician.</p> <p>Findings include:</p> <p>1. During the 4/18/12 observation period between 5:35 AM and 8:10 AM, at the group home, staff #5 removed client H's black TED hose on both feet to check the client's feet. Interview with staff #5 on 4/18/12 at 5:51 AM indicated client H supposedly had a sore on his foot. Staff #5 indicated he was not able to locate a sore/area on either of client H's feet. Staff #5 put client H's TED hose back on both legs without applying any creams and/or treatments.</p> <p>Client H's April 2012 Medication Administration Record (MAR) was reviewed on 4/18/12 at 8:10 AM. Client H's 4/12 MAR Neosporin Antibiotic Ointment apply to "sore on top of foot BID (two times a day) until healed."</p>	W0331	<p>Plan of Correction: Nursing staff will be retrained on assessing individuals when appropriate and on following up with physicians when appropriate. Nursing staff will follow up with Client C's physician concerning abnormal lab results. Nursing staff will document the condition of Client H's healed sore on his foot.</p> <p>Preventive Action: Nursing staff will be retrained on assessing individuals when appropriate and on following up with physicians when appropriate.</p> <p>Monitoring: The Director of Health Services will monitor the completion of following up with Client C's physician regarding abnormal lab results, documenting the condition of Client H's healed sore and retraining of the nursing staff.</p> <p>Date to Be Completed By: May 24, 2012 Responsible Party: Director of Health Services</p>	05/24/2012			

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	<p>Client A's 4/12/ MAR indicated staff #5 initialed he applied the 7:00 AM antibiotic ointment to client H's foot. Client H's 4/12 MAR indicated facility staff initialed they had been applying the Neosporin Ointment to client H's foot two times a day (7 AM and 9 PM) since 4/1/12 when the 4/12 MAR was started.</p> <p>Client H's record was reviewed on 4/19/12 at 2:30 PM. Client H's 4/12 physician's order indicated client H had an order to apply Neosporin Antibiotic Ointment to "sore on top of foot BID (two times a day) until healed."</p> <p>Client H's 3/12 and 4/12 Monthly Nursing Notes did not indicate any documentation in regard to client H's foot. The 4/12 Monthly nursing note did not indicate the client's foot had been monitored by the nurse and/or indicate if the client's foot had been healed.</p> <p>Interview with staff #5 on 4/18/12 at 8:09 AM indicated staff #5 did not apply the Neosporin to client H's foot. Staff #5 indicated he initialed the MAR as it was still on the MAR to administer. Staff #5 indicated he was not allowed to discontinue the Neosporin as the nurse had to discontinue the medication on the MAR.</p>						

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	<p>Interview with administrative staff #2 and staff #1 on 4/19/12 at 8:10 AM indicated staff #5 should not have initialed he administered/applied the Neosporin Ointment. Administrative staff #2 and staff #1 indicated they did not know how long client H's foot had been healed. Administrative staff #2 and staff #1 indicated facility staff should have called the nurse to discontinue the order/treatment.</p> <p>Interview with administrative staff #1, #2 and #3 on 4/20/12 at 11:00 AM indicated they did not know how the area on client H's foot had been healed. Administrative staff #1 indicated the facility staff should have contacted the nurse to have the treatment removed from the MAR.</p> <p>2. Client C's record was reviewed on 4/19/12 at 1:47 PM. Client C's 1/30/12 Pharmacy review recommended the facility obtain a Depakote level for client C's seizure medication. Client C's record indicated a Depakene (generic form) level was obtained on 3/1/12. The 3/1/12 Depakene level indicated the client's Depakote/Depakene level was at "108.7 H" (high) as the lab indicated a normal range of 50 to 100.</p> <p>Client C's 3/1/12 lab and/or 3/12 nursing notes did not indicate the facility</p>						

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	<p>contacted client C's physician in regard to the 3/1/2 high Depakote level.</p> <p>Interview with LPN #1 on 4/20/12 at 12:09 PM indicated he would have to check his notes to see if client C's doctor had been informed of client C's high Depakote lab. LPN #1 did not provide any additional documentation and/or information in regard to the high Depakote level.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>This deficiency was cited on 3/12/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				