| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G437 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 06/13/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GIBSON COUNTY ARC STOUT ST | 1015 S STOUT ST<br>PRINCETON, IN 47670 |

| (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 |
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| W000000 | This visit was for a recertification and state licensure survey.<br><br>Survey Dates: June 10, 11, 13, 2014<br><br>Facility Number: 000951<br>Aims Number: 100244590<br>Provider Number: 15G437<br><br>Surveyor: Mark Ficklin, QIDP<br><br>These deficiencies reflect state findings in accordance with 460 IAC 9.<br>Quality Review completed 6/20/14 by Ruth Shackelford, QIDP. | W000000 | | |
| W000249 | 483.440(d)(1)<br>PROGRAM IMPLEMENTATION<br>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 individual program plan.<br>Based on observation, record review, and interview, the facility failed for 2 of 3 sampled clients (#2, #3) to ensure the clients' communication and privacy training programs were implemented | W000249 | As of June 26, 2014, all staff has been retrained on individual program plans and the | 06/26/2014 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | when opportunities were present.<br><br>Findings include:<br><br>An observation at the group home was done on 6/13/14 from 6:46a.m. to 8:00a.m. Client #3 was observed to eat breakfast at 7:18a.m. Client #3 was not prompted by staff to sign during her meal. At 7:38a.m., client #2 had received a verbal prompt to change his clothes after breakfast. Client #2 was observed to undress in his bedroom with the door open.<br><br>The record of client #2 was reviewed on 6/13/14 at 11:22a.m. Client #2's 10/11/13 individual support plan (ISP) indicated client #2 had a training program for disrobing. The plan indicated client #2 was to be prompted to change clothes in the privacy of his bedroom.<br><br>The record of client #3 was reviewed on 6/13/14 at 10:05a.m. Client #3's 2/25/14 ISP indicated client #3 had a communication training program to sign two new words daily.<br><br>Interview of professional staff #1 on 6/13/14 at 11:52a.m. indicated client #2 should be assisted with dressing to ensure client privacy. Staff #1 indicated client #3 had a communication program to sign. | | importance of following each individual's goals. Staff has also been retrained on the importance of teaching consumers about privacy.<br><br>No other clients were affected by the deficient practice.<br><br>The facility will monitor to ensure the deficient practice does not reoccur by reminding staff of the importance of continually following, teaching, and working with individuals on their goals and privacy on a quarterly basis via staff completing the Consumer Program | |

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| | Staff #1 indicated client #3 was signing eat, drink, yes, no, medicine and bucket. Staff #1 indicated the clients' training programs should have been implemented at all opportunities.<br><br>9-3-4(a) | | Plans and Active Treatment in-service.<br><br>The weekend supervisor, assistant manager and home manager, whom work in the home on a daily basis, will be responsible for completing the on site teaching, training, modeling of all training objectives. | |
| W000264 | 483.440(f)(3)(iii)<br>PROGRAM MONITORING & CHANGE<br>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.<br>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the facility, to review the restrictive intervention: facility practice of | W000264 | As of June 23, 2014, HRC approval has been obtained for all individuals who have any form of restriction placed on them. The QIDP was trained on obtaining HRC for restrictions on a yearly basis. No clients have been affected by the deficient practice | 06/26/2014 |

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| | restricting client access to sharp knives.<br><br>Findings include:<br><br>An observation was done on 6/10/14 at the group home from 4:15p.m. to 5:18p.m. Staff #3 was interviewed on 6/10/14 at 4:44p.m. Staff #3 indicated the group home kept the sharp knives locked due to a client's behavior and client safety.<br><br>Record review of the facility's HRC reviews from 6/1/13 to 6/13/14 was done on 6/13/14 at 11:28a.m. There was no documentation the HRC had reviewed the facility's restrictive practice of restricting clients' (#1, #2, #3, #4, #5, #6) access to sharp knives.<br><br>Interview of professional staff #1 on 6/13/14 at 11:52a.m. indicated the facility restriction of locked sharp knives had not been presented to and reviewed by the facility's HRC.<br><br>9-3-4(a) | | due to individuals having access to them with staff assistance. The facility will monitor to ensure the deficient practice does not reoccur by having HRC for restrictions renewed each year in January for the February meeting. Also, staff will continue to assist the individuals with the items when requested. | |