

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591
---	--

(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
W0000	<p>This visit was for a post-certification revisit (PCR) survey to the fundamental annual recertification and state licensure survey completed on 9/12/11.</p> <p>This survey was done in conjunction with the investigation of complaint #IN00101314.</p> <p>Dates of Survey: 12/20, 12/21, 12/22 and 12/28/11</p> <p>Provider Number: 15G095 Facility Number: 000634 AIM Number: 100233980</p> <p>Surveyors: Paula Chika, Medical Surveyor III, Team Leader</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 1-5-12 by C. Neary, Program Coordinator.</p>	W0000		
W0240	<p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the client's Individual Program Plan (IPP) failed to indicate when client B was to use a walker .</p>	W0240	W240 Plan of Correction: Client B's IPP will be updated to include when he is to use his walker. Preventive Action: Staff will be trained on the new IPP addendum. The Q-D will be	01/15/2012

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591		
(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	
	<p>Findings include:</p> <p>During the 12/20/11 observation period between 3:10 PM and 6:50 PM, at the group home, client B ambulated independently without the use of any adaptive equipment and/or devices.</p> <p>Client B's record was reviewed on 12/21/11 at 12:52 PM. Client B's 9/30/11 Contact Note indicated client B was using a walker to ambulate as the client was "...standing in the middle of the doorway and not going out."</p> <p>Client B's 9/1/11 IPP did not indicate client B utilized a walker when ambulating. Client B's 9/1/11 IPP and/or record did not indicate the client required and/or needed the use of a walker to ambulate.</p> <p>Interview with administrative staff #2 and #3 on 12/22/11 at 10:00 AM indicated client B could walk independently without a walker. Administrative staff #2 indicated she was not aware client B used a walker when ambulating. Administrative staff #3 stated client B required the use of a walker a few months ago when the client was "paranoid" and going through a stage where he thought he was going to fall. Administrative staff #2</p>		<p>trained on appropriately adding adaptive equipment to each IPP. Monitoring: The QMRP-D will ensure each IPP has a thorough list of all adaptive equipment and directions for use. Date to Be Completed By: January 15, 2012 Responsible Party: Director of Residential Services, QMRP-D</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/28/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591
---	--

(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
W0252	<p>and #3 indicated the use of the walker and when to use was not part of the client's IPP.</p> <p>This deficiency was cited on 9/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to document the client's 30 minute checks which were being done at night.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 12/21/11 at 12:07 PM. Client A's 5/8/11 (sic) IPP addendum indicated "Per his behavior plan, [client A] needs to be supervised closely. Staff should check on him every 5 minutes during awake hours, and every 30 minutes during sleep hours."</p> <p>Client A's 10/1/11 Behavior Support Plan (BSP) indicated the client would steal and hoard food due to the client's Prader Willi diagnosis (genetic disorder which causes extreme insatiable appetite resulting in morbid obesity). The 10/11 BSP</p>	W0252	<p>W252 Plan of Correction: A form will be developed for staff to utilize to document Client A's 30 minute bed checks. Staff will document these bed checks. Preventive Action: Staff will be retrained on 30 minute bed checks for client A and document that client A has been checked. The Q-D will be trained on appropriate times to require tracking. Monitoring: The Q-D will ensure that the check is being documented. Date To Be Completed By: January 15, 2012 Responsible Party: Director of Residential Services, QMRP-D</p>	01/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591		
(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	
W0262	<p>indicated "...8. Staff should perform bed checks on client every 30 minutes throughout the night..." Client A's 8/26/11 IPP and/or 10/1/11 BSP did not indicate the facility staff documented the 30 minutes done during the night.</p> <p>Interview with administrative staff #2, #3 and staff #1 on 12/22/11 at 10:00 AM indicated facility staff completed 30 minute checks at night due to the client's food stealing behavior. Administrative staff #2 indicated the staff were not documenting the 30 minutes checks with client A.</p> <p>9-3-4(a) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on interview and record review for 1 of 4 sampled clients with restrictive programs (client C), the facility failed to have its Human Rights Committee review and/or approve a behavior medication which was being used for sedation due to the client's behavior.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 12/21/11 at 1:22 PM. Client C's 9/27/11</p>	W0262	<p>W262</p> <p>Plan of Correction: Human Rights Committee will review and approve Client C's Diazepam 10 mg for dental appointments.</p> <p>Preventive Action: The QMRP-D and nurse will be retrained on HRC procedure.</p> <p>Monitoring: The Administrative Assistant will monitor appropriate HRC approvals.</p>	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591		
(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	
	<p>physician's order indicated the client had an order for Diazepam (behavior medication for sedation) 10 milligrams by mouth 1 hour prior to dental appointments.</p> <p>Client C's 5/8/11 Individual Support Plan (IPP) indicated client C did not receive behavior medications. Client C's 5/8/11 IPP indicated the facility's Human Rights Committee did not review and/or approve the restrictive program/use of the Diazepam.</p> <p>Interview with administrative staff #1, #2, #3 and staff #1 on 12/22/11 at 10:00 AM indicated client C received Diazepam for sedation for dental appointments. Administrative staff #2 and #3 indicated they thought the facility's Human Rights Committee had reviewed and approved the use of the Diazepam. Administrative staff #2 and #3 did not provide documentation the facility's Human Rights Committee had reviewed and approved the restrictive program/use.</p> <p>This deficiency was cited on 9/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>		<p>Date To Be Completed By: January 15, 2012 Responsible Party: QMRP-D, Administrative Assistant</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591		
(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	
W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to ensure staff weighed the client daily as ordered.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 12/21/11 at 12:07 PM. Client A's 9/27/11 physician's order indicated client A's diagnosis included, but was not limited to Prader Willi Syndrome (genetic disorder which causes extreme insatiable appetite resulting in morbid obesity). Client A's 9/27/11 physician's orders indicated client A had an order "weight every day."</p> <p>Client A's undated Protocol For Daily Weights indicated "[Client A] should be weighed daily...."</p> <p>Client A's Blood Pressure/Pulse/Weight Record (kept at the Baker Center-office for the group home) for 11/2011 indicated client A was being weighed daily at the Baker Center Monday through Friday. Client A's 12/11 Medication Administration Record (MAR) indicated client A was not weighed on 12/3, 12/10, 12/11, 12/17 and 12/18/11.</p> <p>Client A's 10/3/11 Training Record</p>	W0331	<p>W331 Plan of Correction: Client A will be weighed daily. Daily weights will be documented. Preventive Action: Staff will be retrained on weighing Client A daily and documenting his daily weights or documenting refusals when he refuses to be weighed. Monitoring: Nursing staff will monitor the completion of Client A's daily weights. Date To Be Completed By: January 15, 2012 Responsible Party: Director of Health Services</p>	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/28/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE VINCENNES, IN47591		
(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	
	<p>indicated was reviewed on 12/21/11 at 11:50 AM. Client A's training record indicated facility staff were to weigh the client daily between 9:00 AM and 11:00 AM. The training record if the client was weighed at the group home and the scale showed a weight gain, client A was to be brought to the Baker Center to be weighed on the scale in the medication room.</p> <p>Interview with LPN #1 and #2 on 12/22/11 at 12:30 PM indicated facility staff should be weighing the client on the weekends on the group home's scale. LPN #1 and #2 indicated the staff was having trouble getting client A's weight as he would refuse to let staff see the reading on the scale. LPN #1 and #2 indicated the 11/11 MAR did not indicate the client refused to let staff weigh him.</p> <p>This deficiency was cited on 9/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				