

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 9, 10, 13, 2015</p> <p>Provider Number: 15G689 Aims Number: 200333130 Facility Number: 002939</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility failed to exercise operating direction over the facility to provide a safe and clean environment for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) living in the group home.</p> <p>Findings include:</p> <p>An observation of clients #1, #2, #3, #4, #5, #6, #7 and #8 (at the group home) was done on 4/9/15 from 4:10p.m. to 6:08p.m. The observation included the following environmental condition: the living room carpet had a 2 inch to 3 inch wide tear down the entire length of the</p>	W 0104	<p>Plan of Correction: Maintenance ticket will be entered and maintenance will determine if new carpet, laminate or linoleum would be best. New flooring will be installed in the living room area.</p> <p>Maintenance ticket will be entered for refrigerator handle.</p> <p>Preventive Action: KCARC will train all Group Home staff on proper procedures for reporting maintenance issues. Maintenance will complete monthly maintenance checklist.</p> <p>Monitoring: Assistant Program Coordinator or Program Coordinator will be in the home weekly to identify maintenance issues.</p> <p>Responsible Party:</p>	05/13/2015

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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W 0156 Bldg. 00	<p>living room; the refrigerator handle was broken off.</p> <p>Interview of staff #2 on 4/9/15 at 4:20p.m.. indicated the group home carpeting and refrigerator door were in need of replacement. Staff #2 indicated they were not aware of any work orders in place to replace the carpeting and refrigerator door handle.</p> <p>9-3-1(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed for 1 of 3 reportable incident investigations reviewed (client #6), to ensure reportable incident investigation results were reported to the administrator within five working days.</p> <p>Findings include:</p> <p>Record review of the facility's reportable incident reports was done on 4/10/15 at 11:48a.m. An incident report on 3/20/15 indicated client #6 had been left at home</p>	W 0156	<p>Manager, Assistant Program Coordinator, Program Coordinator and Maintenance. Date to be completed: Assessments and bids will be completed by May 13th 2015. Installation will follow a timeline provided by vendor selected for installation. Refrigerator handle will be remedied by May 13th 2015.</p> <p>Plan of Correction: Key administrative staff will be retrained on proper investigation procedures. Preventive Action: Key administrative staff will be retrained on proper investigation procedures. Monitoring: Director of Residential and Community Support Services will ensure procedures are followed. Responsible Party: Director of Residential and Community Support Services Date to be completed: May 13th 2015.</p>	05/13/2015	

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W 0255 Bldg. 00	<p>alone. The facility had documented an investigation had been initiated on 3/20/15. There was no documentation to indicate the date the investigation findings/summary had been reported to the facility's administrator.</p> <p>Professional staff #3 was interviewed on 4/13/15 at 11:54a.m. Staff #3 indicated the investigation had begun on 3/20/15 and there was no documentation of the completion date (sent to administrator). Staff #1 indicated the investigation documentation did not indicate the investigation results were reported in 5 working days.</p> <p>9-3-2(a)</p> <p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on interview and record review of 1 of 4 sampled clients (#4), the Qualified Intellectual Disabilities Professional (QIDP), failed to revise the Individual Program Plan (IPP) in regards to client</p>	W 0255	<p>Plan of Correction: Assistant Program Coordinator/ProgramCoordinator will review current IPP's and make changes as needed.</p> <p>Preventive Action: Assistant</p>	05/13/2015			

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W 0436 Bldg. 00	<p>(#4) having successfully completed objectives identified in his IPP.</p> <p>Findings include:</p> <p>Client #4's record review was completed on 4/13/15 at 10:13a.m. Client #4's documented monthly training program data for 11/14 through 2/15 indicated client #4 had met at 100% every month the training programs: shave with an electric razor, preparation of a meal, and apply toothpaste to his toothbrush. It was documented, on the 11/24/14 review, "revisions needed."</p> <p>Professional Staff #1 was interviewed on 4/13/15 at 11:54a.m. Staff #1 indicated client #4's goals should have been considered met and revised by the QIDP.</p> <p>9-3-4(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>		<p>Program Coordinator/Program Coordinator will be retrained regarding when to update individuals IPP's or create new objective as they notice a need. Monitoring: Program Coordinator will review progress for goals during 90 day meeting period. Responsible Party: Assistant Program Coordinator/Program Coordinator Date to be completed: May 13th 2015</p>	

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	<p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#3) with adaptive equipment, to provide client #3 with training for his refusal to wear his prescribed eyeglasses.</p> <p>Findings include:</p> <p>Observations were done at the group home on 4/9/15 from 4:10p.m. to 6:08p.m. and on 4/13/15 from 6:54a.m. to 8:00a.m. Observations were done at the facility's day program on 4/13/15 from 8:47a.m to 9:42a.m. Client #3 did not wear, nor was he prompted to wear, eyeglasses during the observations.</p> <p>Record review of client #3 was done on 4/13/15 at 9:45a.m. Client #3's 2/20/15 eye exam indicated client #3 had physician prescribed eyeglasses for "needs glasses to wear full time." Client #3's individual program plan (IPP) was dated 5/1/14. Client #3's IPP did not have documentation of a training program in place to address client #3's refusal to wear prescribed eyeglasses.</p> <p>Interview of professional staff #1 (qualified intellectual disabilities professional, QIDP) on 4/13/15 at 11:54a.m. indicated client #3 had eyeglasses prescribed for full time wear.</p>	W 0436	<p>Plan of Correction: IDT meeting will be held with participant to determine if he wants to follow through with the recommendation.</p> <p>Preventive Action: Assistant Program Coordinator/Program Coordinator/Nurse will be retrained regarding the need for IDT meetings to address health care recommendations.</p> <p>Monitoring: Program Coordinator/Nurse will review recommendations from appointments.</p> <p>Responsible Party: Program Coordinator/Nurse</p> <p>Date to be completed: May 13th 2015</p>	05/13/2015	

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	Staff #1 indicated client #3 often refused to wear his eyeglasses. Staff #1 indicated client #3 did not have a training program in place to address his refusal of wearing eyeglasses. 9-3-7(a)				