

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G623	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 2	STREET ADDRESS, CITY, STATE, ZIP CODE 410 LIBERTY BICKNELL, IN 47512
--	--

(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 000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 14, 15, 16 and 17, 2015.</p> <p>Provider Number: 15G623 Aims Number: 100249470 Facility Number: 001182</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 incidents reviewed for allegations of (physical aggression) client to client abuse (client #2).</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 4/16/15 at 11:12a.m. A reportable incident report, dated 1/27/15,</p>	W 154	<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. The Director of Residential and Community Support Services will review and sign off on all investigations. Responsible Party: Director of Residential and</p>	05/16/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G623	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2015
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 2			STREET ADDRESS, CITY, STATE, ZIP CODE 410 LIBERTY BICKNELL, IN 47512		
(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 client #2 was upset at the facility operated day program and pushed a peer. The report indicated the peer fell backwards hitting a table and the floor. The report indicated the peer went to the emergency room. There was no documented investigation completed.</p> <p>Professional staff #1 was interviewed on 4/16/15 at 3:04p.m. Staff #1 indicated there was no documented investigation for client to client aggression which occurred on 1/27/15 between client #2 and a peer at the day program. Staff #1 indicated the facility should have completed an investigation for the client to client aggression which resulted in a an emergency room visit.</p> <p>9-3-2(a)</p>		<p>Community Support Services Date to be completed: May 16th 2015.</p>		
W 255 Bldg. 00	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE 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. Based on interview and record review of</p>	W 255	Plan of Correction: Assistant	05/13/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G623	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 2	STREET ADDRESS, CITY, STATE, ZIP CODE 410 LIBERTY BICKNELL, IN 47512
--	--

(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>3 of 4 sampled clients (#1, #2, #4), the Qualified Intellectual Disabilities Professional (QIDP), failed to revise the Individual Program Plan (IPP) in regards to clients (#1, #2, #4) having successfully completed objectives identified in their IPPs.</p> <p>Findings include:</p> <p>Client #1's record review was completed on 4/16/15 at 11:32a.m. Client #1's documented monthly training program data for 9/14 through 2/15 indicated client #1 had met at 100% every month the training programs to: put 10 alphabet letters in order (A-J), state 3 symptoms of the flu, prepare a meal weekly, and verbally count to 20.</p> <p>Client #2's record review was completed on 4/16/15 at 10:08a.m. Client #2's documented monthly training program data for 9/14 through 2/15 indicated client #2 had met at 100% every month the training programs to: identify 3 symptoms of a common cold, prepare medication (pop out one pill), read and discuss a news article, and cash a check at the bank.</p> <p>Client #4's record review was completed on 4/16/15 at 12:16p.m. Client #4's documented monthly training program</p>		<p>Program Coordinator/Program Coordinator will review current IPP's and make changes as needed.</p> <p>Preventive Action: Assistant Program Coordinator/Program Coordinator will be retrained regarding when to update individuals IPP's or create new objective as they notice a need.</p> <p>Monitoring: Program Coordinator will review progress for goals during 90 day meeting period.</p> <p>Responsible Party: Assistant Program Coordinator/Program Coordinator</p> <p>Date to be completed: May 13th 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G623	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 2	STREET ADDRESS, CITY, STATE, ZIP CODE 410 LIBERTY BICKNELL, IN 47512
--	--

(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>data for 9/14 through 2/15 indicated client #4 had met at 100% every month the training programs to: pop a pill out at medication pass, learn group home phone number, identify value of coins, and identify 3 symptoms of a common cold.</p> <p>Professional staff #1 was interviewed on 4/16/15 at 3:04p.m. Staff #1 indicated clients #1, #2 and #4's goals should have been considered met and revised by the QIDP.</p> <p>9-3-4(a)</p>			