

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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
W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00124811.</p> <p>Complaint #IN00124811: Unsubstantiated due to lack of evidence.</p> <p>Dates of Survey: March 5, 6, 7 and 8, 2013</p> <p>Provider Number: 15G689 Aims Number: 200333130 Facility Number: 002939</p> <p>Surveyors: Mark Ficklin, Medical Surveyor III, Team Leader Paula Chika, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 15, 2013 by Dotty Walton, Medical Surveyor III.</p>			W000000			

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: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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			
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, for 2 of 4 sampled clients (B, D), the facility failed to ensure the rights of all clients, by not ensuring clients B and D had their own properly fitting clothing.</p> <p>Findings include:</p> <p>An observation was done at the group home on 3/5/13 from 4:07p.m. to 6:52p.m. The following client clothing issues were identified:</p> <p>At 5:10p.m., client B was assisted by staff #1 out of a dining room chair to a wheelchair. When client B stood up and walked with staff assistance her pants fell to her ankles. Staff #1 pulled client B's pants back up when they had reached her wheelchair. Staff #1 took client B to her bedroom and changed her pants. At 5:22p.m. staff #1 stated client B's pants were "too big," stretched out and without a drawstring. Staff #1 indicated the pants were not client B's.</p> <p>At 5:32p.m. client D was sitting in her</p>	W000137	<p>W137 Plan of Correction: Manager will ensure that each individual has a change of their own clothing at the Baker Center at all times. Preventive Action: Day Services Coordinator will be retrained to contact the Manager when more clothing is needed. The Manager will be retained to get clothes up here as they are requested. Monitoring: Day Services Coordinator will monitor clothing Date to Be Completed By: April 7, 2013 Responsible Party: Day Services Coordinator and Manager</p>	04/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
---	---

(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>wheelchair with her pants down to her middle thigh region. Client D's adult "depends" (incontinency brief) and part of her buttocks were exposed. At 5:52p.m., staff #7 stated client D's pants were "too big." Staff #7 stated the pants "belonged to [client A]." Staff #7 stated client D "probably" got the pants while at the day service.</p> <p>Staff #2 was interviewed on 3/7/13 at 3:24p.m. Staff #2 indicated clients B and D had their own pants available which fit them and they should have worn their own clothing.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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			
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview, the facility failed for 1 of 4 sampled clients (C) to include, in client C's individual program plan (IPP)/behavior support plan (BSP), reactive interventions in regards to when to use gloves and wrist guard for mouthing/biting of hands.</p> <p>Findings include:</p> <p>The record of client C was reviewed on 3/7/13 at 1:30p.m. Client C's 5/25/12 IPP/BSP indicated client C had interventions in place to address his biting/mouthing of his hands. The BSP included an 8/29/12 addendum that indicated the use of gloves and wrist guards to cover the affected areas. The IPP/BSP did not indicate when staff were to apply the gloves/wrist guard and how long he was to wear the gloves/wrist guard.</p> <p>Professional staff #1 was interviewed on 3/7/13 at 3:24p.m. Staff #1 indicated client C's IPP/BSP did not indicate when staff were to use the gloves/wrist guard and how long client C was to wear them.</p> <p>9-3-4(a)</p>	W000240	<p>W240 Plan of Correction: IPPS and BSPS will be updated to ensure all restrictive interventions are listed as well as how and when to sue them correctly. Preventive Action: Manager will be retrained on when it is appropriate to update BSP and IPP. Monitoring: Coordinator will monitor the accurate completion of each IPP and BSP. Date to be Completed By: April 7, 2013 Responsible Party: Coordinator</p>	04/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 4 sampled clients (B, C, D) to ensure the clients' communication training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>During the 3/5/13 observation period between 4:07p.m. and 6:52p.m. and observation on 3/6/13 between 6:10 AM and 7:30 AM, at the group home, clients B, C and D were non-verbal in communication in that the clients did not speak. Staff #6, #7, #9, and #10 did not provide any communication training with clients B, C and D during both observations. Prior to leaving for work, staff #9 assisted client D to go to the bathroom. Client D was not encouraged to use any sign language.</p> <p>Client B's record was reviewed on 3/7/13 at 11:05a.m. Client B's 5/2/12 Individual Program Plan (IPP) indicated the client</p>	W000249	<p>W249</p> <p>Plan of Correction: Staff will be retrained on active treatment and implementing communication training when opportunities are present.</p> <p>Preventive Action: Staff will be retrained on active treatment and implementing communication training when opportunities are present.</p> <p>Monitoring: The Manager will be in the home at least three times a week to observe active treatment. Manager will ensure that communication training is occurring when opportunities are present</p> <p>Date to be Completed By: April 7, 2013</p> <p>Responsible Party: Coordinator</p>	04/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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>had an objective to use American Sign Language (ASL) for toilet. Client B was to indicate the need to toilet, which facility staff did not implement when formal and/or informal opportunities for training existed.</p> <p>Client C's record was reviewed on 3/7/13 at 1:30p.m. Client C's 6/1/12 IPP indicated the client had an objective to demonstrate the ASL for bathroom which facility staff did not implement when formal and/or informal opportunities existed.</p> <p>Client D's record was reviewed on 3/7/13 at 12:06p.m. Client D's 9/1/12 IPP indicated client D had an objective to use ASL for bathroom which facility staff did not implement when formal and/or informal opportunities for training existed.</p> <p>Staff #3 (Director) was interviewed on 3/7/13 at 3:24p.m. Staff #3 indicated clients B, C and D had communication programs that should have been implemented when opportunities were present.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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	
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation and interview, the facility failed for 1 non-sampled client (G), to ensure client G received the nursing services as indicated by his current health status. Client G was sent to day service program with a temperature and no follow up care at the day program.</p> <p>An observation was done on 3/6/13 at the group home from 6:10 AM to 7:30 AM. Interview with staff #1 on 3/6/13 at 6:12 AM indicated client (G) had a temperature and a sore throat, and was in his bedroom as the client did not feel well. At 6:25 AM, client (G) was prompted to come to the medication room to get his morning medications. Client (G) came into the medication room and spoke to the staff in the room. As client (G) was waiting to get his medications, the client sneezed into his hand and visibly sprayed the room area as he sneezed. Staff #7 told staff (unknown male), client (G) had a temperature over a 100 degrees before receiving Tylenol (pain and temperature reliever).</p> <p>An observation was done on 3/6/13 at the facility owned day service from 11:22a.m. to 1:14p.m. Client G was at the day service. At 11:45a.m client G pushed a</p>	W000331	<p>W331</p> <p>Plan of Correction: Staff and Nurses will be retrained on reasons to keep an individual home from day services or work. Staff will also be retrained that the nurse is the one who makes the decision to keep home and they must follow all nursing orders.</p> <p>Preventive Action: Staff and Nurses will be retrained on reasons to keep an individual home from day services or work. Staff will also be retrained that the nurse is the one who makes the decision to keep home and they must follow all nursing orders.</p> <p>Monitoring: Health Services Coordinator will ensure that all individual are healthy while at Day programming. If an individual needs to go home for a reason after arriving to day services nursing will immediately find a manager to get the individual home.</p> <p>Date to be Completed By: April 7, 2013</p> <p>Responsible Party: Health Services Coordinator, Day Services Coordinator, Manager</p>	04/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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>food cart to the kitchen, went back to his group and wiped his nose with a tissue.</p> <p>Day program staff #11 was interviewed on 3/6/13 at 12:19p.m. Staff #11 indicated no one had told them client G was sick (had a temperature) today prior to his coming to the day service. Staff #11 indicated client G had been blowing his nose today. Staff #11 indicated no nurses had checked on client G while at the day service. Staff #11 took client G's temperature at 12:23p.m. Staff #11 indicated client G had a temperature of 100.7 degrees and staff #11 sent this information to the nurse. At 12:47p.m. facility nurse #4 checked on client G. Nurse #4 indicated client G's temperature was 100 degrees and he was going home.</p> <p>Staff #8 (nurse) was interviewed on 3/6/13 at 12:58p.m. Staff #8 indicated they had been on-call for the group home. Staff #8 indicated they had received a call client G had a temperature and was given Tylenol. Staff #8 indicated they had another call around 7:00a.m. and were told client G had no temperature and wanted to go to day program. Staff #8 indicated client G was allowed to go to the day program. Staff #8 indicated there had been no follow up with client G at the day program. Staff #4 (nurse) indicated they were the nurse for the group home</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
---	---

(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>and were not aware client G had been running a temperature and was sent to the day program. Nurse #4 indicated it was the facility policy "if a client has a temperature of 100 degrees or more they are to stay home." Nurse #4 indicated client G should have stayed home on the morning of 3/6/13.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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	
W000436	<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>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (D) with adaptive equipment, to ensure client D's communication device, "Take and Talk," was in good repair.</p> <p>Findings include:</p> <p>Observations were done on 3/5/13 from 4:07p.m. to 6:52p.m. and on 3/6/13 from 6:10a.m. to 7:30a.m. at the group home. Client D did not use any communication devices during the observations.</p> <p>Record review for client D was done on 3/7/13 at 12:06p.m. Client D's 9/1/12 individual program plan (IPP) indicated client D was to use a "Take and Talk" communication device. Client D's IPP indicated client D had a training program to use the communication device to indicate "more" at meal times. Client D's IPP program data documentation from 9/1/12 through 3/7/13 indicated the communication device was broken. There was no date documented regarding the</p>	W000436	<p>W436 Plan of Correction: Staff will be retrained on how and when to fill out the Adaptive Equipment Checklist. Preventive Action: Staff will be retrained on how and when to fill out the Adaptive Equipment Checklist. Monitoring: Manager will check all adaptive equipment in the home once weekly. Date to be Completed By: April 7 2013. Responsible Party: Manager</p>	04/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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>status of the broken communication device.</p> <p>Interview of professional staff #2 on 3/7/13 at 3:24p.m. indicated client D had a communication device. Staff #2 indicated the device was probably broken since 9/12 but there was no documented date when the device was broken, when it was sent for repair or the device's current repair status.</p> <p>9-3-7(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591			
(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			
W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview and record review for 1 additional client (G), the facility failed to encourage a sick client (G) to wash his hands after sneezing into them to prevent the spread of infection.</p> <p>Findings include:</p> <p>During the 3/6/13 observation period 6:10 AM to 7:30 AM at the group home, client (G) was prompted to come to the medication room to get his morning medications at 6:25 AM. Client (G) came into the medication room and spoke to the staff in the room. As client (G) was waiting to get his medications, the client sneezed into his hand and visibly sprayed the area as he sneezed. Staff #7 and a second staff (unknown) stated "Bless you." Staff #7 and unknown staff did not encourage client (G) to wash his hands. Client G walked out of the room touching the door handle and other objects without washing his hands and/or using hand sanitizer to prevent the spread of infection/illness. Staff #7 told staff (unknown male), client (G) had a temperature "over a 100" degrees before receiving Tylenol (pain and temperature</p>	W000455	<p>w455</p> <p>Plan of Correction: A training objective will be developed for Client G to wash his hands after coughing or sneezing into them. Preventive Action: The Manager will be retrained on developing training objectives when appropriate. Staff will be retrained on the importance for everyone to wash their hands to keep from spreading infections to other individuals Monitoring: The Coordinator will monitor the accurate development of all training objectives. Date to be Completed By: April 7, 2013 Responsible Party: Coordinator</p>	04/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591
---	---

(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>reliever).</p> <p>Interview with staff #1 on 3/6/13 at 6:12 AM indicated client (G) had a temperature and a sore throat, and was in his bedroom as the client did not feel well.</p> <p>Interview with staff #3 (Director) on 3/7/13 at 3:24p.m. indicated client G should have been directed to wash his hands after sneezing into them.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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	
W009999	<p>State Findings</p> <p>The following Community Residential Facilities Rule for Persons with Developmental Disabilities was not met.</p> <p>460 IAC 9-3-3(e) Facility Staffing</p> <p>(e) Prior to assuming residential duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 4 facility staff personnel files (staff #5, #6) reviewed, the facility failed to ensure staff #5 and #6 had written</p>	W009999	<p>w999</p> <p>Plan of Correction: Health services will ensure that all staff working have current TB test Preventive Action: Health Services staff will be retrained on the TB test procedure. Staff will be retrained that when they receive the email that states they need to come in for their TB that they get that done in the time frame presented, or they will be pulled from the schedule until it is completed and returned with satisfactory results. Monitoring: Health Services will ensure that all employees maintain a current TB test on file with KCARC Date to be completed: April 7 th 2013 Responsible Party: Heath Services Coordinators and Medical assistants.</p>	04/07/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G689	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 2918 E ARC AVE BLDG 101 VINCENNES, IN 47591		
(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>evidence of annual Mantoux or chest x-rays.</p> <p>Findings include:</p> <p>Staff personnel files were reviewed on 3/6/13 at 1:28p.m. Staff #5's most recent documented Mantoux or chest x-ray was completed on 12/29/11. Staff #6's most recent documented Mantoux or chest x-ray was completed on 10/20/11.</p> <p>Interview of professional staff #7 on 3/6/13 at 1:40p.m., indicated there was no written evidence of a Mantoux or chest X-ray for staff #5 since 12/11 and #6 since 10/11.</p> <p>9-3-3(e)</p>				