STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX COUNTY ARC - BICKNELL 1	628 W 7TH ST 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	This visit was for an investigation of complaint #IN00171576. Complaint #IN00171576: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W104, W122, W148, W149, W154, W157, W210, W331 and W9999. Unrelated deficiencies cited. Dates of survey: April 21, 22, 23, and 24, 2015. Facility Number: 000732 Provider Number: 15G202 AIM Number: 100243240 These deficiencies reflect state findings in accordance with 460 IAC 9.	W 000		
W 104	483.410(a)(1) GOVERNING BODY			

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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Bldg. 00	The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 3 sampled clients (client B), the governing body failed to exercise general policy and operating direction over the facility to ensure: __All falls with injuries were reported to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective services) per IC 12-10-3 according to state law for client B. __An injury of unknown origin (fracture) was investigated. __Sufficient safeguards were implemented to prevent client B from repeated falls and injury and to ensure client B was monitored/supervised by staff. Findings include: 1) The governing body failed to implement its policy and procedures to ensure two falls with injuries for client B were reported to BDDS per IAC 9-3-19(b)(5) according to state law. The governing body failed to exercise operating direction over the facility to ensure safeguards were implemented for client B to decrease the frequency and	W 104	Plan of Correction: Group Home staff will be retrained on reportable incidents. Key administrative staff will be retrained on reportable incidents and when investigations are warranted. Preventive Action: Group Home staff will be retrained on reportable incidents. Key administrative staff will be retrained on reportable incidents and when investigations are warranted. Additional administrative oversight will be placed in the home with addition of another Assistant Manager to the team. Monitoring: Director of Residential and Community Support Services will review all incident reports and investigations to ensure procedures are followed. Responsible Party: Director of Residential and Community Support Services	05/24/2015

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	severity of his falls. The governing body failed to ensure an injury of unknown origin (fracture) was investigated. Please see W149. 2) The governing body failed to exercise operating direction over the facility to ensure client B's falls with injuries were reported to BDDS. Please see W9999. 3) The governing body failed to ensure an injury of unknown origin (fracture) was investigated for client B. Please see W154. This federal tag relates to complaint #IN00171576. 9-3-1(a)			
W 122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review for 1 of 3 sampled clients (client B), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement written policy	W 122	Plan of Correction: Group Home staff will be retrained onreportable incidents. Key administrative staff will be retrained on reportableincidents and when investigations are warranted. Key	05/24/2015

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	and procedures to ensure falls with injuries for client B were immediately reported to BDDS (Bureau of Developmental Disabilities) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure an unknown injury with severe injury (fracture) was investigated. The facility failed to ensure sufficient safeguards were in place to protect client B from repeated falls and injuries. Findings include: 1) The facility failed to implement its policy and procedures to ensure two falls with injuries for client B were reported to BDDS per IAC 9-3-19(b)(5) according to state law and to ensure an injury of unknown origin (fractured hip) was investigated. The facility failed to have the Interdisciplinary Team (IDT) meet to discuss the trend of falls and to implement safeguards to keep the falls from recurring. The facility failed to ensure the staff notified nursing after client B had two falls for proper assessment. Please see W149. 2) The facility failed to ensure an injury of unknown origin (fracture) was investigated for client B. Please see W154.		administrative staff willbe retrained on ensuring proper safeguards are in place. Preventive Action: GroupHome staff will be retrained on reportable incidents. Key administrative staffwill be retrained on reportable incidents and when investigations arewarranted. Key administrative staff will be retrained on ensuring propersafeguards are in place. Additional administrative oversight will be placed inthe home with addition of another Assistant Manager to the team. Monitoring: Director of Residential and Community SupportServices will review all incident reports and investigations to ensureprocedures are followed. Responsible Party: Directorof Residential and Community Support Services	

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	3) The facility failed to report two falls with injuries to the Bureau of Developmental Disabilities Services (BDDS) per state rules. Please see W9999. This federal tag relates to complaint #IN00171576. 9-3-2(a)			
W 137 Bldg. 00	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. Based on observation and interview for 1 of 3 sampled clients, (client C), the facility failed to ensure the client was provided clothing that was appropriately sized. Findings include:	W 137	Plan of Correction: Participant clothing in the home will bechecked to ensure that it fits well. Preventive Action: Grouphome and key administrative staff will be retrained on participant's rights anddignity. Additional administrativeoversight will be	05/24/2015

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	During observation at the group home on 4/21/2015 between 3:00PM and 4:30PM, client C was seen pulling up his pants 10 times. Client C was not wearing a belt. Interview with staff #6 was conducted on 4/21/2015 at 4:00PM. She stated "Because [client C] tightens his belt too tight, it affects his circulation around his waist, and we don't let him wear one. We're going to the store next week to get [client C] new clothes that fit better." 9-3-2(a)		placed in the home with addition of another Assistant Managerto the team. Monitoring: Assistant Program Coordinator, Group HomeManager and Assistant Manager will monitor participants clothing needs. Responsible Party: AssistantProgram Coordinator, Group Home Manager and Assistant Manager	
W 148 Bldg. 00	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on record review and interview for 1 of 3 sampled clients (Client B), the facility failed to notify his Health Care Representative (HCR) of two falls with injuries.	W 148	Plan of Correction: Key administrative staff will be retrained on reportable incidents andthe need to contact all guardians when significant health issues arise. Keyadministrative staff will be	05/24/2015

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	Findings include: Record review of client B's MAR (Medication Administration Record) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee. Record review of the facility's incident report regarding client B's 4/4/2015 fall was completed on 4/22/2015 at 2:59 PM. It indicated on 4/4/2015 at 1:00 PM, client B had fallen while attempting to get up from his recliner while not using his walker and fell on the floor. While the incident report indicated staff had "notified the pager", the nurse was not notified to do a follow up assessment of client B. During interview with client B's Health Care Representative/niece on 4/21/2015 at 3:30PM, she stated "I was not aware of the my uncle's fall on 1/8/2015. On approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head." She indicated the group home staff told her client B had fallen a few days before while trying to get up from his recliner in		trained to contact nurse when significant healthissues arise so that nursing staff can complete appropriate follow up. Preventive Action: Keyadministrative staff will be retrained on reportable incidents and the need tocontact all guardians when significant health issues arise. Key administrativestaff will be trained to contact nurse when significant health issues arise sothat nursing staff may respond appropriately. Monitoring: Director of Residential and Community SupportServices will review all incident reports and to ensure procedures arefollowed. Responsible Party: Directorof Residential and Community Support Services.	

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	the living room. During interview with the Program Coordinator on 4/22/2015 at 11:45 AM, she indicated client B's Health Care Representative should have been notified. This federal tag relates to complaint #IN00171576. 9-3-2(a)			
W 149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 of 3 sampled clients (client B), the facility neglected to implement its policy and procedures to ensure: __An injury of unknown origin (fracture) was investigated. __Sufficient safeguards were implemented to protect client B from	W 149	Plan of Correction: Group Home staff will be retrained onreportable incidents. Key administrative staff will be retrained on reportableincidents and when investigations are warranted. Key administrative staff willbe retrained on the need to ensure protective measures are in place tosafeguard participants.	05/24/2015

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	repeated falls with injury and to ensure client B was monitored/supervised by staff. __Falls with injury were reported to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include: 1) Record review of client B's MAR (Medication Administration Record) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee. The report did not indicate the nature and/or extent of client B's injuries. During interview with the Program Coordinator on 4/22/2015 at 11:45AM, she stated "There was no incident report turned in by the group home staff" regarding the 1/8/2015 fall. She also stated "As a result, it was not reported to BDDS." The facility nurse was interviewed at 11:05AM on 4/22/2015. She indicated she was not notified client B had fallen on 1/8/2015 and therefore did not		Preventive Action: GroupHome staff will be retrained on reportable incidents. Key administrative staffwill be retrained on reportable incidents and when investigations arewarranted. Key administrative staff will be retrained on the need to ensureprotective measures are in place to safeguard participants. Additionaladministrative oversight will be placed in the home with addition of anotherAssistant Manager to the team. Monitoring: Director of Residential and Community SupportServices will review all incident reports and to ensure procedures arefollowed. Responsible Party: Directorof Residential and Community Support Services	

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	conduct a nursing assessment on him. 2) Interview with staff #4 was conducted at the group home on 4/21/2015 at 4:30PM. She indicated client B had fallen on or about the 4th of April. She stated "I filled out an incident report concerning the fall. I'm not sure what happened to it afterwards." The incident report regarding this fall was not located until the following day. During interview with client B's Health Care Representative/niece on 4/21/2015 at 3:30PM, she stated "During the first week of April, I visited the group home and noticed [client B] had a noticeable knot on his head. I was not aware of the my uncle's fall on 1/8/2015. On approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head. The bump was a approximately 2 inches long and 1.5 inches wide and raised about 3/4 inch. It was black and blue in color." She indicated the group home staff told her client B had fallen a few days before while trying to get up from his recliner in the living room. Client B's record review was completed on 4/22/2015 at 9:05AM. It did not indicate client B's 4/4/2015 fall was reported to BDDS.			

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	The Program Coordinator was interviewed on 4/22/2015 at 11:50AM. She stated "I was just informed an incident report was found at the group home this morning. It was regarding [client B]'s fall in the living room of the group home on 4/4/2015." She stated "The fall was not reported to BDDS per the facility's Policy and Procedures." The Participant Accident / Incident Report dated 4/4/2015 indicated at 1:00PM "[client B] got up from his recliner and didn't use the walker and fell in front of it. Staff helped him up and checked him out. Filled out incident report and called the pager." The facility nurse was interviewed on 4/22/2015 at 11:05AM. She stated "I was not notified of [client B]'s fall on 4/4/2015. There was not a nursing assessment done regarding his fall." 3) A review of client B's records was completed on 4/22/2015 at 9:05AM. An Incident Initial Report was sent to BDDS on 4/13/2015 at 1:30PM. It indicated "[client B] had complaint of pain in the right leg and stomach. Individual was taken to the Emergency Room (ER) at [name of hospital]. He received x-rays to the right leg and hip; Computed			

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	Tomography (CT) scan to stomach, and blood work. CT scan of stomach was unremarkable. X-rays showed a fracture to the right hip. [Client B] was admitted to [name of hospital] for treatment." There was no incident report completed by the group home staff regarding any injury causing event prior to this hospital evaluation. Group home staff #5 was interviewed on 4/22/2015 at 7:55AM. She stated "I arrived at work (group home) on the evening of 4/12/2015 at 11:45PM. I was talking to staff #6 at 12:01 AM and heard [client B] scream 'HELP! NURSE'. I ran into the client's bedroom and he had fallen on the floor with his head underneath the bedrails of his roommate's bed. His walker was on its side next to him." She indicated she called 911 and the paramedics arrived, stabilized him and then transported him to the hospital. Review of client B's medical records from the hospital was completed on 4/21/2015 at 1:40PM. The Report of Operation dated 4/14/2015 at 2:17PM indicated the orthopedic surgeon had completed a surgical repair of the fractured bone utilizing a rod and screws or "open reduction, internal fixation intertrochanteric fracture right femur."			

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	Client B's record review was completed on 4/22/2015 at 9:05AM. Client B's Risk Issues dated 11/1/2014 indicated staff is to assist client B with ambulation as needed and any falls will be reported to the nurse and the physician. It also indicated staff will utilize a gait belt to assist client B with transfers and ambulation as needed. Interview with staff #4 was conducted at the group home on 4/21/2015. She indicated client B did not care to wear the gait belt and staff usually did not have it on him while transferring and ambulating client B. The Assistant Program Coordinator #1 was interviewed on 4/22/2015 at 11:05AM. She stated while "the 4/13/2015 Incident Initial Report to BDDS regarding [client B]'s fall on the same morning did not indicate the cause, it was the result of his fall at 12:01AM that morning." She also stated an investigation wasn't initiated because "we knew it was from the fall." Interview with the Program Coordinator was completed on 4/22/15 at 11:50AM. She indicated an investigation was not initiated regarding client B's 4/13/2015 fall in his bedroom at the group home. She stated "An investigation should have			

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	been done." She also stated "[client B]'s fall on 1/8/2015 should have been reported to BDDS as well as his fall on 4/4/2015. The nurse should have been contacted to do a nursing assessment on the client also." The Program Coordinator also stated "the Interdisciplinary Team (IDT) should have met after the client's 1/8/2015 and 4/4/2015 falls to discuss implementation of safeguards such as a audio baby monitor and more frequent bed checks to minimize client B's future risk of injury/falls." Review of the KCARC (Knox County ARC) "Neglect, Abuse, Battery, Exploitation policy and incident report, reasonable suspicion of a criminal activity and investigatory procedure" dated 4/15/2013 on 4/22/15 at 8:55 AM indicated: "It is the policy of KCARC that any acts of neglect, abuse, battery, and exploitation by any person will not be tolerated. All such cases are to be reported and investigated. Staff, employees and volunteers are expected to have a thorough understanding of all facets of this policy. Any involvement in perpetrating battery, exploitation, material abuse, neglect against a [sic] individual or any failure to report in			

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	according with the following requirements may be grounds for disciplinary action up to and/or termination. POLICY: Each staff, employee or volunteer involved, witnessing or becoming aware of an incident which involves an allegation that neglect, abuse, battery, exploitation, violation of any individual's rights, individual to individual aggression resulting in significant injury, identifying and injury of unknown source/origin has occurred must complete the appropriate internal reporting form, The incident must be reported to the designated administrator as identified on page 1 immediately and to external agencies as described herein within within the regulatory required time requirements." This federal tag relates to complaint #IN00171576. 9-3-2(a)			

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(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 154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for an injury of unknown origin reviewed, the facility failed to ensure an injury of unknown origin (fracture) was investigated for 1 of 3 sampled clients, (client B). Findings include: A review of client B's records was completed on 4/22/2015 at 9:05AM. An Incident Initial Report was sent to BDDS	W 154	Plan of Correction: Key administrative staff will beretrained on reportable incidents and when investigations are warranted Preventive Action: Keyadministrative staff will be retrained on reportable incidents and wheninvestigations are warranted Monitoring: Director of Residential and Community SupportServices will review all incident reports and to ensure procedures arefollowed. Responsible Party: Directorof	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/24/2015

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	(Bureau of Developmental Disabilities Services) on 4/13/2015 at 1:30PM. It indicated "[client B] had complaint of pain in the right leg and stomach. Individual was taken to the Emergency Room at [name of hospital]. He received x-rays to the right leg and hip; Computed Tomography (CT) scan to stomach, and blood work. CT scan of stomach was unremarkable. Xrays showed a fracture to the right hip. [Client B] was admitted to [name of hospital] for treatment." There was no incident report completed by the group home staff regarding any injury causing event prior to this hospital evaluation. Group home staff #5 was interviewed on 4/22/2015 at 7:55AM. She stated "I arrived at work (group home) on the evening of 4/12/2015 at 11:45PM. I was talking to [staff #6] at 12:01 AM and heard [client B] scream 'HELP! NURSE'. I ran into the client's bedroom and he had fallen on the floor with his head underneath the bedrails of his roommate's bed. His walker was on its side next to him." She indicated she called 911 and the paramedics arrived, stabilized him and then transported him to the hospital. Review of client B's medical records from the hospital was completed on 4/21/2015 at 1:40PM. The Report of		Residential and Community Support Services	

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	Operation dated 4/14/2015 at 2:17PM indicated the orthopedic surgeon had completed a surgical repair of the fractured bone utilizing a rod and screws (open reduction, internal fixation intertrochanteric fracture right femur). The Assistant Program Coordinator was interviewed on 4/22/2015 at 11:05AM. She stated while "the 4/13/2015 Incident Initial Report to BDDS regarding [client B]'s fall on the same morning did not indicate the cause, it was the result of his fall at 12:01AM that morning." She also stated an investigation wasn't initiated because "we knew it was from the fall." Interview with the Program Coordinator was completed on 4/22/15 at 11:50AM. She indicated an investigation was not initiated regarding client B's 4/13/2015 fall in his bedroom at the group home. She stated "An investigation should have been done." This federal tag relates to complaint #IN00171576. 9-3-2(a)			

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W 157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 3 sampled clients (client B), the facility failed to take sufficient corrective action to address a pattern of falls. Findings include: 1) Record review of client B's MAR (Medication Administration Record) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee. The report did not indicate the nature and/or extent of client B's injuries. During interview with the Program Coordinator on 4/22/2015 at 11:45AM, she stated "There was no incident report turned in by the group home staff" regarding the 1/8/2015 fall. She also stated "As a result, it was not reported to BDDS." The facility nurse was interviewed at	W 157	Plan of Correction: Key administrative staff will beretrained on the need to ensure protective measures are in place to safeguardparticipants especially when a pattern of falls develops. Preventive Action: Keyadministrative staff will be retrained on the need to ensure protectivemeasures are in place to safeguard participants especially when a pattern offalls develops. Monitoring: Director of Residential and Community SupportServices will review all incident reports and will work with nursing staff toimplement appropriate safeguards for participants with a pattern of falls. Responsible Party: Directorof Residential and Community Support Services	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 1		STREET ADDRESS, CITY, STATE, ZIP CODE 628 W 7TH ST BICKNELL, IN 47512	

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	11:05AM on 4/22/2015. She indicated she was not notified client B had fallen on 1/8/2015 and therefore did not conduct a nursing assessment on him. 2) Interview with staff #4 was conducted at the group home on 4/21/2015 at 4:30PM. She indicated client B had fallen on or about the 4th of April. She stated "I filled out an incident report concerning the fall. I'm not sure what happened to it afterwards." The incident report regarding this fall was not located until the following day. During interview with client B's Health Care Representative/niece on 4/21/2015 at 3:30PM, she stated "During the first week of April, I visited the group home and noticed [client B] had a noticeable knot on his head. I was not aware of the my uncle's fall on 1/8/2015. On approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head. The bump was a approximately 2 inches long and 1.5 inches wide and raised about 3/4 inch. It was black and blue in color." She indicated the group home staff told her client B had fallen a few days before while trying to get up from his recliner in the living room. The Program Coordinator was			

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	interviewed on 4/22/2015 at 11:50AM. She stated "I was just informed an incident report was found at the group home this morning. It was regarding [client B]'s fall in the living room of the group home on 4/4/2015." She stated "The fall was not reported to BDDS per the facility's Policy and Procedures." The Participant Accident / Incident Report dated 4/4/2015 indicated at 1:00PM "[client B] got up from his recliner and didn't use the walker and fell in front of it. Staff helped him up and checked him out. Filled out incident report and called the pager." The facility nurse was interviewed on 4/22/2015 at 11:05AM. She stated "I was not notified of [client B]'s fall on 4/4/2015. There was not a nursing assessment done regarding his fall." 3) A review of client B's records was completed on 4/22/2015 at 9:05AM. An Incident Initial Report was sent to BDDS on 4/13/2015 at 1:30PM. It indicated "[client B] had complaint of pain in the right leg and stomach. Individual was taken to the Emergency Room (ER) at [name of hospital]. He received x-rays to the right leg and hip; Computed Tomography (CT) scan to stomach, and blood work. CT scan of stomach was			

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	unremarkable. X-rays showed a fracture to the right hip. [Client B] was admitted to [name of hospital] for treatment." There was no incident report completed by the group home staff regarding any injury causing event prior to this hospital evaluation. Group home staff #5 was interviewed on 4/22/2015 at 7:55AM. She stated "I arrived at work (group home) on the evening of 4/12/2015 at 11:45PM. I was talking to staff #6 at 12:01 AM and heard [client B] scream 'HELP! NURSE'. I ran into the client's bedroom and he had fallen on the floor with his head underneath the bedrails of his roommate's bed. His walker was on its side next to him." She indicated she called 911 and the paramedics arrived, stabilized him and then transported him to the hospital. Review of client B's medical records from the hospital was completed on 4/21/2015 at 1:40PM. The Report of Operation dated 4/14/2015 at 2:17PM indicated the orthopedic surgeon had completed a surgical repair of the fractured bone utilizing a rod and screws or "open reduction, internal fixation intertrochanteric fracture right femur." Client B's record review was completed on 4/22/2015 at 9:05AM. Client B's Risk			

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	Issues dated 11/1/2014 indicated staff is to assist client B with ambulation as needed and any falls will be reported to the nurse and the physician. It also indicated staff will utilize a gait belt to assist client B with transfers and ambulation as needed. Interview with staff #4 was conducted at the group home on 4/21/2015. She indicated client B did not care to wear the gait belt and staff usually did not have it on him while transferring and ambulating client B. The Assistant Program Coordinator #1 was interviewed on 4/22/2015 at 11:05AM. She stated while "the 4/13/2015 Incident Initial Report to BDDS regarding [client B]'s fall on the same morning did not indicate the cause, it was the result of his fall at 12:01AM that morning." She also stated an investigation wasn't initiated because "we knew it was from the fall." During client B's record review completed on 4/22/15 at 9:05 AM, the records did not indicate client B been reassessed due to his pattern of falls. The client's fall on 4/13/2015 resulted in a fracture to the right hip which required immediate surgery.			

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	Interview with the Program Coordinator was completed on 4/22/15 at 11:50AM. She indicated an investigation was not initiated regarding client B's 4/13/2015 fall in his bedroom at the group home. She stated "An investigation should have been done." She also stated "[client B]'s fall on 1/8/2015 should have been reported to BDDS as well as his fall on 4/4/2015. The nurse should have been contacted to do a nursing assessment on the client also." The Program Coordinator also stated "the Interdisciplinary Team (IDT) should have met after the client's 1/8/2015 and 4/4/2015 falls to discuss implementation of safeguards such as a audio baby monitor and more frequent bed checks to minimize client B's future risk of injury/falls." This federal tag relates to complaint #IN00171576. 9-3-2(a)			
W 210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview,	W 210	-	05/24/2015

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	for 1 of 3 sampled clients (Client B), the facility failed to ensure his pattern of falls was reassessed. Findings include: 1) Record review of client B's MAR (Medication Administration Record) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee. 2) The Program Coordinator was interviewed on 4/22/2015 at 11:50AM. She stated "I was just informed an incident report was found at the group home this morning. It was regarding [client B]'s fall in the living room of the group home on 4/4/2015." During interview with client B's niece on 4/21/2015 at 3:30 PM, she stated "on approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head." She indicated the group home staff told her client B had fallen a few days before while trying to get up from his recliner in the living room.		Plan of Correction: Key administrative staff will beretrained on the need to update an IPP to ensure protective measures are inplace to safeguard participants especially when a pattern of falls develops. Preventive Action: Keyadministrative staff will be retrained on the need to update an IPP to ensureprotective measures are in place to safeguard participants especially when apattern of falls develops. Monitoring: Director of Residential and Community SupportServices will review all incident reports and will work with nursing staff toimplement appropriate safeguards for participants with a pattern of falls.Safeguards addressed will be added to IPP's. Responsible Party: Directorof Residential and Community Support Services	

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	The Participant Accident / Incident Report dated 4/4/2015 indicated at 1:00 PM "[client B] got up from his recliner and didn't use the walker and fell in front of it. Staff helped him up and checked him out. 'Filled out incident report and called the pager." During client B's record review completed on 4/22/15 at 9:05 AM, the records did not indicate client B been reassessed due to his pattern of falls. The client's fall on 4/13/2015 resulted in a fracture to the right hip which required immediate surgery. Interview with the Program Coordinator was completed on 4/22/15 at 11:50 AM. The Program Coordinator stated "The nurse should have been contacted to do a nursing assessment on the client also." The Program Coordinator also stated "the Interdisciplinary Team (IDT) should have met after the client's 1/8/2015 and 4/4/2015 falls to discuss implementation of safeguards to minimize [client B's] future risk of injury/falls." This federal tag relates to complaint #IN00171576. 9-3-4(a)			

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W 312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 3 sampled clients (clients B and C) who took a behavior control medication, the facility failed to ensure the medication was part of the client's Behavioral Support Plan (BSP) which also included a plan of reduction and for 1 of 3 sampled clients (client C), the facility's Health Care Services failed to track data in regards to the client's diagnosis of dementia. Findings include: 1) Review of client B's record was completed on 4/22/2015 at 9:05 AM.	W 312	Plan of Correction: Program staff will review all BSP's toensure behavior medications are listed in each plan. Method for dementiatracking will be developed and implemented. Preventive Action: Programstaff will be retrained on elements to be included in BSP's. Program staff willbe trained on methods for tracking dementia. Monitoring: Director of Residential and Community SupportServices or Behavior Management staff will review all BSP's to ensure behaviormedications are listed appropriately. Nursing staff will work with Director ofResidential and Community Support Services to	05/24/2015

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	Client B's Individual Program Plan (IPP) dated 11/1/2014 indicated client B's diagnoses included, but were not limited to, Alzheimer's Disease, Vascular Dementia with Psychotic Tendencies, and Depression. Client B's Medication and Treatment Record dated 4/1/2015 to 4/30/2015 indicated client B received the behavior control medication Trazodone 50 milligrams (mg) at bedtime for sleep, Nuedexta 20/10 mg for uncontrolled crying spells, and Donepezil 10 mg for Alzheimer's Disease. The IPP failed to include these three behavior control medications in a plan which included withdrawal criteria. Interview with the Nurse on 4/22/2015 at 11:05 AM indicated client B did not have these current behavior control medications addressed in his IPP nor was there a plan of reduction for the medications. 2) Review of client C's was completed on 4/22/2015 at 10:08 AM. Client C's IPP dated 8/1/2014 indicated client C's diagnoses included, but were not limited to, Moderate Mental Retardation and Autism. Client C's Medication and Treatment record dated 4/1/2015 to 4/30/2015 indicated client C received the behavior control medication Clonazepam 1 mg twice daily. It did not indicate		ensure dementia tracking is inplace for any participants with dementia. Responsible Party: Directorof Residential and Community Support Services	

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	which behavior the client was taking the medication. Client C's Medication and Treatment record also indicated he received Fluoxetine 40 mg daily and Seroquel 600 mg twice daily. The IPP failed to include this two behavior control medications as well as a plan which included withdrawal criteria. Interview with the Nurse on 4/22/2015 at 11:05 AM indicated client C did not have these current behavior control medications Fluoxetine and Seroquel addressed in his IPP nor was there a plan of reduction for the medications. She also stated "the facility does not have a tracking system in placed to monitor the progress of the Alzheimer's Disease nor the effectiveness of the Donepezil." 9-3-5(a)			

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W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 sampled clients (client B), the facility's nursing services failed to assess the client after two falls with injuries. Findings include: 1) Record review of client B's MAR (Medication Administration Record) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee.	W 331	Plan of Correction: Key administrative staff will beretrained on reportable incidents. Key administrative staff will be trained tocontact nurse when significant health issues arise so that nursing staff cancomplete appropriate follow up. Preventive Action: Keyadministrative staff will be retrained on reportable incidents. Keyadministrative staff will be trained to contact nurse when significant healthissues arise so that nursing staff can complete appropriate follow up. Monitoring: Director of Residential and Community SupportServices will review all incident reports and to ensure procedures arefollowed. Responsible Party: Director of Residential and Community Support Services.	05/24/2015

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	The facility nurse was interviewed at 11:05 AM on 4/22/2015. She indicated she was not notified client B had fallen on 1/8/2015 and therefore did not conduct a nursing assessment. 2) The Program Coordinator was interviewed on 4/22/2015 at 11:50AM. She stated "I was just informed an incident report was found at the group home this morning. It was regarding [client B]'s fall in the living room of the group home on 4/4/2015." During interview with client B's niece on 4/21/2015 at 3:30PM, she stated "on approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head." She indicated the group home staff told her client B had fallen a few days before while trying to get up from his recliner in the living room. The Participant Accident / Incident Report dated 4/4/2015 indicated at 1:00PM "[client B] got up from his recliner and didn't use the walker and fell in front of it. Staff helped him up and checked him out. 'Filled out incident report and called the pager.'" The facility nurse was interviewed at 11:05 AM on 4/22/2015. She indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G202	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 04/24/2015
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC - BICKNELL 1		STREET ADDRESS, CITY, STATE, ZIP CODE 628 W 7TH ST BICKNELL, IN 47512	

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	she was not notified client B had fallen on 4/4/2015 and therefore did not conduct a nursing assessment. This federal tag relates to complaint #IN00171576. 9-3-6(a)			
W 999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless of the severity of the injury.	W 999	Plan of Correction: Group Home staff will be retrained onreportable incidents. Key administrative staff will be retrained on reportableincidents and when investigations are warranted. Preventive Action: GroupHome staff will be retrained on reportable incidents. Key administrative staffwill be retrained on reportable incidents and when investigations arewarranted. Additional administrative oversight will be placed inthe home with addition of another Assistant Manager to the team. Monitoring: Director of Residential and Community SupportServices will review all incident reports and investigations to	05/24/2015

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	This state rule was not met as evidenced by: Based on record review and interview for 2 of 3 incident reports reviewed affecting client B, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) for falls with injury in a timely manner. Findings include: 1) Record review of client B's MAR (Medication Administration Report) binder at the group home was completed on 4/22/2015 at 8:15AM. A form entitled "Record of Possible Injury" completed by Direct Support Staff #3 indicated client B had fallen on 1/8/2015 at 5:45 PM in the living room - his knee gave out and he hit his head and left knee. During interview with the Program Coordinator on 4/22/2015 at 11:45AM, she stated "there was no incident report turned in by the group home staff" regarding the 1/8/2015 fall. She also stated "as a result, it was not reported to BDDS." 2) Interview with staff #4 was conducted at the group home on 4/21/2015 at		ensureprocedures are followed. Responsible Party: Directorof Residential and Community Support Services	

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	4:30PM. She stated that client B had fallen on or about the 4th of April. She stated "I filled out an incident report concerning the fall. I'm not sure what happened to it afterwards." During interview with client B's niece on 4/21/2015 at 3:30PM, she stated "on approximately the 6th of April, I visited the group home and noticed [client B] had a noticeable knot on his head." She indicated the group home staff told her [client B] had fallen a few days before while trying to get up from his recliner in the living room. Client B's record review was completed on 4/22/2015 at 9:05AM. It did not indicate client B's 4/4/2015 fall was reported to BDDS. The Program Coordinator was interviewed on 4/22/2015 at 11:50AM. She stated "I was just informed an incident report was found at the group home this morning. It was regarding client B's fall in the living room of the group home on 4/4/2015." She stated "the fall was not reported to BDDS per the facility's Policy and Procedures." The Participant Accident / Incident Report dated 4/4/2015 indicated at 1:00PM "[client B] got up from his			

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	recliner and didn't use the walker and fell in front of it. Staff helped him up and checked him out. 'Filled out incident report and called the pager.'" 9-3-1(b)			