

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 10/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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
W0000	<p>This visit was for the recertification and state licensure survey.</p> <p>Dates of Survey: October 16, 17, 22 and 23, 2012.</p> <p>Provider Number: 15G095 Aims Number: 100233980 Facility Number: 000634</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 2, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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 10/23/2012	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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			
W0104	<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 10/16/12 from 4:08p.m. to 6:24p.m. The observation included the following environmental condition: the living room and dining room had worn, stained and ripped carpeting. On the dining room wall was a large door bell with the cover off and exposed wires.</p> <p>Interview with staff #1 on 10/22/12 at 12:22p.m. indicated the living room and dining room carpet was torn and stained. Staff #1 indicated the door bell had exposed wires and was in need of a cover. Staff #1 indicated they were not aware of any work orders in place to repair the doorbell and to acquire replacement carpet.</p> <p>9-3-1(a)</p>	W0104	<p>W104</p> <p>Plan of Correction: The living room and dining room carpet will be replaced. The doorbell will be repaired so no wires are showing. Preventive Action: Staff will be retrained on reporting maintenance concerns appropriately. Monitoring: Maintenance will perform monthly checks of the home.</p> <p>Date to Be Completed By: November 22, 2012</p> <p>Responsible Party: Quality Service Management Director</p>	11/22/2012			

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 10/23/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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: 15G095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/23/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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	
W0156	<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 2 of 5 reportable incident investigations reviewed (clients #1, #4, #8), to ensure reportable incident investigation results were reported to the administrator within five working days.</p> <p>Findings include:</p> <p>Record review of facility reportable incidents was done on 10/16/12 at 1:08p.m. The incident reports and investigations indicated: 1) Client #4 had a reportable incident report and investigation on 7/30/12 in which police had been called. There was no documentation the investigation findings/summary had been reported to the facility administrator. 2) Clients #1 and #8 had a physical altercation with injury on 9/15/12. The facility investigation did not document when the investigation had been completed and when the facility administrator had been informed of the findings.</p> <p>Staff #1 was interviewed on 10/22/12 at 12:28p.m. Staff #1 indicated the</p>	W0156	<p>W156 Plan of Correction: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. The administrator will be made aware within 5 days of the date the initial incident report was filed. Preventive Action: The Investigation Summary Form will be revised to include the date the administrator was made aware of the results of the investigation. All members of the investigation team will be trained by the Director of Residential and Adult Day Services to make the Director of Residential and Adult Day Services aware of the results of each investigation within 5 days and to document appropriately on the Investigation Summary. Monitoring: The Quality Assurance Coordinator will monitor the accurate and timely completion of all abuse/neglect/exploitation/illegal activity investigations. The Administrative Assistant will monitor the accurate and timely completion of all other investigations. Date to be Completed By: November 22, 2012 Responsible Party: Director of</p>	11/22/2012	

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 10/23/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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>investigation of client #4's 7/30/12 incident and clients #1 and #8's 9/15/12 incident investigations did not document when the facility administrator had been informed of the investigation results.</p> <p>9-3-2(a)</p>		Residential and Adult Day Services		

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 10/23/2012	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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			
W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (#2, #3), to ensure client #2's individual program plan (IPP) had a training program in place to address his identified dental hygiene needs and client #3's IPP addressed his identified training needs with personal space and money.</p> <p>Findings include:</p> <p>1. During the facility observations on 10/16/12 from 4:08p.m. to 6:24p.m. and on 10/17/12 from 5:58a.m. to 7:30a.m., client #3 was in staff, peers and a visitor's personal space without redirection. Client #3 would hug others and attempt to kiss their hands. Staff were not prompting client #3 to observe others' personal space and to shake hands appropriately.</p> <p>Record review for client #3 was done on 10/22/12 at 9:50a.m. Client #3 had a 9/1/12 IPP. Client #3's IPP did not address his identified training need regarding personal space. Client #3's IPP indicated client #3 needed money training with "identifying and exchanging money."</p>	W0227	<p>W227 Plan of Correction: Client 2's individualized plan will be revised to include a training program for dental hygiene. Client 3's individualized plan will be revised to include training programs for personal space and money. Preventive Action: The Manager will be retrained on writing an IPP that meets the individual's needs. Monitoring: The Coordinator will monitor the accurate completion of each IPP. Date to be Completed By: November 22, 2012 Responsible Party: Coordinator</p>	11/22/2012			

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 10/23/2012	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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>Client #3's IPP did not have any training programs in place to address this identified need.</p> <p>2. Record review for client #2 was done on 10/22/12 at 11:15a.m. Client #2 had a 2/16/12 dental exam that indicated "poor hygiene" and client #2 had 6 cavities and needed one extraction. Client #2 had a 2/14/12 IPP. Client #2's IPP did not address his identified dental hygiene needs.</p> <p>Staff #1 was interviewed on 10/22/12 at 12:28p.m. Staff #1 indicated client #3 often was in others' personal space. Staff #1 indicated client #3 also had identified money training needs. Staff #1 indicated client #3 did not have training programs in place to address these identified needs. Staff #1 indicated client #2 was admitted to the facility with poor dental hygiene during 1/12. Staff #1 indicated client #2 did not have any training programs in place to address his dental hygiene needs.</p> <p>9-3-4(a)</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 10/23/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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	
W0249	<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 (#1, #3, #4), to ensure the clients' medication training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation at the group home was done on 10/16/12 from 4:08p.m. to 6:24p.m. Client #1 received his medication at 4:15p.m. Staff #4 administered client #1's medication Depakote for seizures and Klonopin for behaviors. Staff #4 did not implement any medication training during the medication pass. Client #4 received his medication at 4:24p.m. Client #4 received the medication Geodon for behaviors. Client #4 was not asked to identify his Geodon. Client #3 received his medication at 4:29p.m. Client #3 received a calcium (supplement) pill. Staff #4 punched out client #3's medication and gave the medication to client #3.</p>	W0249	<p>W249</p> <p>Plan of Correction: Staff will be retrained on active treatment and implementing medication training when opportunities are present. Preventive Action: Staff will be retrained on active treatment and implementing medication training when opportunities are present. Monitoring: The Manager will be in the home during a medication pass at least twice per week. The Manager will ensure that medication training is occurring when opportunities are present. Date to be Completed By: November 22, 2012 Responsible Party: Manager</p>	11/22/2012	

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 10/23/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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>The record of client #1 was reviewed on 10/22/12 at 12:08p.m. Client #1's 9/5/12 individual program plan (IPP) indicated client #1's medication training program was to repeat the names of his medication.</p> <p>The record of client #3 was reviewed on 10/22/12 at 9:50a.m. Client #3's 9/1/12 IPP indicated client #3's medication training program was to punch out hand over hand his medications into a medication cup.</p> <p>The record of client #4 was reviewed on 10/22/12 at 11:40a.m. Client #4's 7/31/12 IPP indicated client #4's medication training program was to identify Geodon.</p> <p>Interview with staff #1 on 10/22/12 at 12:28p.m. indicated clients #1, #3 and #4's medication training programs should have been implemented at all opportunities.</p> <p>9-3-4(a)</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 10/23/2012	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC				STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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			
W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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 4 sampled clients (#1) with adaptive equipment, to provide client #1 with training for the refusal to wear his prescribed (full time wear) eyeglasses.</p> <p>Findings include:</p> <p>Observations were done at the group home on 10/16/12 from 4:08p.m. to 6:24p.m. and on 10/17/12 from 5:58a.m. to 7:30a.m. An observation was done on 10/17/12 from 10:20a.m. to 12:34p.m. at the day program. Client #1 did not wear nor was he prompted to wear eyeglasses during the observations.</p> <p>Record review for client #1 was done on 10/22/12 at 12:08p.m. Client #1's 9/18/12 eye exam indicated client #1 had prescribed eyeglasses, "wear full time." Client #1 had a 9/5/12 individual program plan (IPP). Client #1's IPP did not have documentation of a training program in place to address client #1's refusal to wear prescribed eyeglasses.</p>	W0436	<p>W436</p> <p>Plan of Correction: A training objective will be developed for Client 1 to wear his glasses full time.</p> <p>Preventive Action: The Manager will be retrained on developing training objectives when appropriate.</p> <p>Monitoring: The Coordinator will monitor the accurate development of all training objectives.</p> <p>Date to be Completed By: November 22, 2012</p> <p>Responsible Party: Coordinator</p>	11/22/2012			

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 10/23/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC			STREET ADDRESS, CITY, STATE, ZIP CODE 1814 WASHINGTON AVE 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>Interview on 10/22/12 at 12:28p.m. with professional staff #1 indicated client #1 had eyeglasses. Staff #1 indicated client #1 refused to wear his eyeglasses. Staff #1 indicated client #1 did not have a training program in place to address the refusal of wearing them.</p> <p>9-3-7(a)</p>				